Maternal and Child Health Services
Title V Block Grant

State Narrative for Indiana

Application for 2011
Annual Report for 2009

Document Generation Date: Tuesday, July 13, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are kept on file at the Indiana State Department of Health in the Finance Department. They are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The State Title V program solicited public comments for this application using several methods. The first method was to place a request for public comments on the Maternal and Child Health (MCH) web page for ongoing public input. The web page encourages the public to comment on the previous, and the current years Title V Block Grant. This includes the Narrative, Forms, and a 2010 Executive Summary which is updated yearly.

A second method for soliciting public comments involved the use of surveys for identifying priority needs for the Five Year Needs Assessment from providers, partners, collaborators, disparity families and families of children with special healthcare needs. The surveys were either used for collecting comments of individuals in group settings, mailed by request to individuals, or electronically e-mailed to professionals. Professionals who were surveyed in small group settings included but were not limited to: Prenatal Substance Abuse (PSUPP) statewide directors, the Indiana Coalition to Improve Adolescent Health (ICIAH) steering committee, the Healthy Families of Indiana Think Tank, Indiana State Department of Health's Chronic Disease Division, State Perinatal Advisory Board, Indiana State Nutrition Council, an Indiana University-Purdue University-Indianapolis nursing class, a Butler University health class, Sunny Start core partners group , Sunny Start Family Advisory Subcommittee, Sunny Start Evaluation Subcommittee, WIC Breastfeeding Committee, the Breast Feeding Center at Clarian, WIC Steering Committee, Indiana Dietitian Associations Meeting, Indiana Nutrition Council, Infant Health & Survival Council, and Indiana's FIMRs .

Needs assessment surveys were sent by e-mail to the 139 member Virtual Advisory Committee, 92 Local Health Departments (LHD) and listed on the LHD Sharepoint, all community health centers, and to all MCH clinics. Surveys were mailed to any professional upon their request. A copy of the Completed Title V Block Grant will be e-mailed to the states public library system for access in their government document sections.

In surveying these small groups and individuals MCH was able to obtain input from a cross section of disciplines. It included but was not limited to the following professions: health service directors, physicians, registered nurses, public health professionals, students, educators, social workers, lactation specialists, Healthy Family Workers, clinic staff, early childhood service providers, outreach workers, WIC staff, registered dieticians, and fundraisers. These individuals reside in over two-thirds of Indiana's 92 counties, but their service delivery systems represent all of Indiana.

A third method for soliciting public comments before the submission of the Title V Block Grant involved the use of a twenty-page MCH Title V Block Grant Executive Summary. The summary was sent out the first week of June 2010 to the expanded 250 Virtual Advisory Committee members, all LHDs, MCH clinics, 131 Indiana libraries, community health centers, MCH Network/Community Partners, and the Minority Health Coalitions. All groups were advised that the Title V Five Year Needs Assessment and Grant Application had to be submitted no later than July 15, 2010. Therefore their deadline for submitting commits could be no later than Friday, June 25th. As of July 6, over 15 reviewers submitted comments. Title V staff have reviewed All comments and have incorporated as many comments as possible into the needs assessment. All public comments received after submission of the current Title V Block Grant will be used during the preparation of the application for the following year.

Loren Robertson, Deputy Commissioner at Indiana State Department of Health (ISDH) commented that smoking during pregnancy is an extremely important issue. A sampling of other public comments include:

"I have read and agree with the goals outlined to meet the state's priority health issues and needs. I found the ten goals that have been identified as needed areas for improvement in Indiana to be appropriate and necessary. I believe the work plan outlined with each of these goals will allow Indiana to attain the projected outcomes."
Kerri A. Kraus, R.N.
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"The goal over the next five years is to reduce the proportion of births that occur within 18 months of a previous birth, to the same mother, to the level of 10% from (INCLUDE CURRENT LEVEL) I WOULD SUGGEST WORKING WITH FATHERHOOD INITIATIVE ON THIS ONE TOO! THEY NEED EDUCATION ABOUT THIS ISSUE MORE THAN MOMS!"
Sarah M. Stelzner, MD
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"As the CEO of Learning Well school-based clinics in Marion County, I would like to offer the mention of our relationship with the State in order to add the power of our large, 9 year collaboration with healthcare providers; school partners; and advisory partners (including local foundations, the United Way of Central Indiana, Health & Hospital Corporation, Clarian….and many others) to an already strong proposal. I have attached a list of the working partnerships and collaborations that are presently in place. I noted there are many areas where Learning Well could be utilized as a prime example of how the State of Indiana has been successful in creating programs that are based upon partnerships and collaborations."
Donna A. Stephens, MBA

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Title V staff will continue to reach out to providers, mothers, families, partners, collaborators and others for continued input into Title V programs and policies.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Since the last Five Year Needs Assessment, Indiana has witnessed changes in the population's strengths and needs. These changes have resulted in the retirement of six SPMs, the modification of two SPMs, and the retention of two of the eight SPMs contained in the last needs assessment. To more accurately target the population's needs, Indiana has developed six new SPMs for this year's needs assessment, creating a total of ten. The following ten SPMs contained in this needs assessment are reflective of the progress Indiana has made in a number of areas in MCH and CSHCS programs. They are also evidence of the continued need to reduce diversity and strengthen the health and well-being of Indiana's mothers, babies, children, children with special health care needs, and women of childbearing ages.

1. Reduce the number of sudden unexpected infant deaths due to SIDS, and accidental suffocation and strangulation in bed 5% yearly. Unsafe sleep practices have been shown to cause Sudden Unexplained Infant Deaths (SUID) including SIDS and unintentional suffocation that occurs when an infant is placed on its stomach to sleep, on an unsafe sleep surface, or shares a sleep surface with adults, other children or pets.
2. Increase the percent of mothers who breastfeed exclusively through three months of age. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth.
3. Decrease the proportion of pregnant women on Medicaid who smoke during pregnancy by 0.5% each year from a baseline of 30% in 2007. Fifty-one percent of all pregnant women in Indiana are on Medicaid at time of birth. Smoking rates among pregnant women on Medicaid have been found to be 1.5 times that for pregnant women not on Medicaid.
4. Increase the percentage of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate to 66.5%. Early and adequate prenatal visits are important for positive birth outcomes. Indiana aims to lower the disparity for black women receiving adequate prenatal care.
5. During FY 2010 the percentage of children age 0 -- 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter will be decreased to .80% of the total children tested. The projection for total tested is 80,000 with 640 elevated.
6. The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 12% in 2009. According to the ISDH report Short Interpregnancy Intervals and the Risks of Adverse Birth Outcomes in Indiana: Statistics from the Live Birth Data 1990-2005, 44.5% of all pregnancies were conceived within 24 months of the last pregnancy, 18.8% were conceived within less than 12 months, and 6.2% in less than 6 months.
7. Decrease Total Preterm Birth rates by 15% by 2015 from 12.9% in 2007 to 10.9% by 2015. B. Decrease late preterm births due to cesarean delivery with no medical reason among Indiana resident births by 50% from 10.2% in 2006 to 5.1% by 2012. In 2009, the March of Dimes announced that Indiana had a failing grade due to a number of perinatal indicators including late preterm births. The consistent escalation of our preterm rate has created major concerns in the public health community and prompted an MCH investigation into the patterns of preterm births and the potential contributing factors.
8. Decrease the percent of high school students who are obese by 3% (from 12.8 to 11.3) over 5 years. The Indiana Healthy Weight Initiative Task Force and DNPA have continued development work on a state obesity prevention plan that addresses issues related to childcare, school settings, and special populations. By the end of June 2010, the Indiana Healthy Weight Initiative Task Force and the DNPA will complete, publish, and disseminate a state plan for obesity

prevention.
9. Reduce the prevalence of Chlamydia and gonorrhea among adolescents ages 15-19 from 13.6% to 12% and 4% to 2.5% respectively. An increase in sexual activity among adolescents and young people in Indiana and the United States has lead to an alarming number of teen pregnancies and an increase in the rates of sexually transmitted infections.
10. (Developmental) Capacity for promoting social and emotional health in children from birth to age 5. Early social and emotional competence is associated with continued competence and may help reduce the risks for later problem behaviors.

Changes in MCH Program Capacity

All State agencies in Indiana have experienced budget cuts from both federal and State sources, resulting in fewer funds available for Indiana's MCH populations. Additionally, Indiana is near the bottom of all states in receipt of federal health dollars. Indiana ranks 48th for amount of Federal funding for public health from the CDC in FY 2009, 50th for Federal funding from HRSA, and 47th for the amount states provide for public health services. The lack of funding not only impacts the public health services that can be provided, but also means that Indiana does not have the personnel to compete with other states for federal funding.

There have been a number of other changes in Title V capacity over the past five years. New leadership (Indiana State Health Commissioner, HHS Assistant Commissioner, MCH Director, CSHCS Director, Oral Health Director, and Director of Life Course Health Systems) has brought new expertise, experience and perspectives to combat public health issues. With this new leadership, MCH is rethinking its previous strategies and initiatives. The leadership is moving toward a life course health systems approach for maternal and child health, recognizing the need for new initiatives that especially target disparity and address socio-economic factors that influence health outcomes. Indiana has also strengthened its Title V capacity through the addition of numerous partners and collaborators in order to improve outcomes throughout the state.

III. State Overview

A. Overview

Indiana is a state rich with the history of an industrial and agricultural past and the promise of an agricultural and high tech future. Like the rest of the country, this past year has forced the State to deal with serious changes and hardships due to the United States' economic downturn. However, Indiana has fared far better than most of its neighbors and most of the country. Under Governor Mitch Daniels' administration, innovative programs have emerged to combat high unemployment and the lack of health insurance that accompanies such changes.

State Introduction

The Indiana State Department of Health (ISDH), one of the largest state agencies, serves the population in a wide variety of ways including providing environmental public health, food protection services, health facility licensing, public health preparedness, health promotion programs, statistical information, direct health services, and many other infrastructure building programs.

The Mission of the ISDH supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities. To achieve this mission, ISDH has adopted principles that guide policy development and programs. These principles mandate that ISDH and its Commissions:

- Focus on data-driven policy to determine appropriate evidence-based programs and initiatives.
- Evaluate activities to ensure measurable results.
- Engage partners and include appropriate intra-agency programs in policy-making and programming.
- View essential partners to include local health departments, physicians, hospitals and other health care providers, other state agencies and officials as well as local and federal agencies and officials, community leaders, businesses, health insurance companies, Medicaid, health and economic interest groups, and other groups outside the traditional public health model.
- Actively facilitate the integration of public health and health care activities to improve Hoosiers' health.

In its desire to make Indiana the healthiest state in the country, ISDH also recognizes that key factors such as prevention of disease, ensuring access to health care, and promoting personal responsibility of individual Hoosiers for their own health must also be an integral part of the state's initiatives. ISDH works hard to collaborate effectively with its many partners in policy-making and programming. ISDH also works hard to develop an environment of respect -- for those who serve Hoosiers in the public health field and the public it serves -- by honoring diversity, equality of opportunity, cultural differences, and ethical behavior.

As of January 2010, the State's Priority Health Initiatives included activities that support data driven efforts for both health conditions and health system initiatives; INShape Indiana; and integration of medical policy that values public health principles; and preparedness. The state is emphasizing the integration of health care policies with evidence-based and results oriented programming. It also continues to highlight preparedness and effective responses to threats that cannot be prevented.

In particular, InShape Indiana is a statewide initiative designed to help Hoosiers make healthier choices about food, physical activity and tobacco. Governor Daniels began this program and remains heavily involved in support of this program. The website link (http://www.in.gov/inshape/) provides access to valuable information and resources that can help Hoosiers live a more healthful life. As a result of the initiative, thousands of Hoosiers have decided to start living a healthier lifestyle by choosing to eat better, move more and avoid tobacco.

Health Status and Health Needs of Hoosiers

In comparison to other states, the health status of Hoosiers is below average. However, Indiana does have certain strengths including a low rate of uninsured population at 11.9%, increasing immunization coverage of children, and decreasing cardiovascular deaths. In the past ten years, immunization coverage increased from 41.8% to 78.4% of children ages 19 to 35 months who received complete immunizations. Since 1990, the rate of deaths from cardiovascular disease decreased from 425.0 to 310.0 deaths per 100,000 population.

In terms of state challenges, Indiana ranks poorly on the prevalence of smoking at 26.0% (the same rate as in 1999); high levels of pollution at 13.2 micrograms of fine particulate per cubic meter; 49th in public health funding at $36 per person; and a high percentage (23.3%) of children in poverty. In the past five years, the percentage of children in poverty increased from 13.7 % to 23.3 % of persons under age 18. Additionally, Indiana ranks 37th in cardiovascular deaths; 37th in cancer deaths; and 39th in overall infant mortality. Compared to 43 other states that have sufficient data, Indiana ranks 40th in terms of black infant mortality. (Infant mortality rates by state 2004-2006, Statehealthfacts.org)

Health disparities are also a very large issue in Indiana. Obesity is more prevalent among non-Hispanic blacks than non-Hispanic whites at 36.7% vs. 27.2 % respectively. The prevalence of diabetes also varies by race and ethnicity in the state; 12.9 % of non-Hispanic blacks have diabetes compared to 7.7 % of Hispanics and 8.4 % of non-Hispanic whites.
In 2007, the total infant mortality rate in Indiana was 7.5 per 1,000. The white non-Hispanic rate was 6.5 per 1,000, the black non-Hispanic rate was 15.7 per 1,000 and the Hispanic rate was 6.8 per 1,000. The low birth weight for infants in Indiana in 2007 was 8.5 % of births. The percentages were 7.8% for white non-Hispanic, 14.1% for black non-Hispanic and 7.2% for Hispanic for low birth weight infants in Indiana in 2007.

Demographics
The State of Indiana is located in the Great Lakes Region of the United States. Indiana is ranked 38th in land area, and is the smallest state in the continental U.S. west of the Appalachian Mountains. Its capital and largest city is Indianapolis, the largest of any state capital east of the Mississippi River. As of 2008, Indiana is the 38th most populated state in the United States with 6,376,792 people living in 2,795,024 households. Indiana has several metropolitan areas with populations greater than 100,000 as well as a number of smaller industrial cities and small towns. Residents of Indiana are known as Hoosiers.

Indianapolis ranks as the 13th largest city and 11th largest metropolitan area in the United States, and also the 3rd largest city in the Midwest. The Indianapolis Metropolitan Area, defined as Marion County and the counties immediately surrounding it, is among the fastest-growing metropolitan areas in the US, with the largest growth centering in the counties surrounding Marion County. (FY2008, US Census Bureau.)

In the state, 26.9% of the population are under the age of 18, 6.9% are under the age of five and 12.8% are 65 years of age or older. The median age is 36.4 years. In 2005, 77.7% of Indiana residents lived in metropolitan counties. In Indiana, the population is 51% female and 49% male.

Indiana has limited cultural diversity outside of its metropolitan areas with over two-thirds of its counties reporting white, non-Hispanic populations of more than 95%. Indiana's overall Hispanic population is 5.2%, its white, non-Hispanic population is 83.2%, and its black non-Hispanic population just over 9%. This contrasts highly with Indiana's largest county, Marion County, which has an African-American population of 25.9%, a Hispanic population of 7.4%, and a white, non-Hispanic population of 63.8%. Asians and people reporting two or more races account for almost all of the remaining 2.9%.

Indiana's economy is considered to be one of the most business-friendly in the United States. This is due in part to its conservative business climate, low business taxes, relatively low union membership, and labor laws. The doctrine of at will employment, whereby an employer can

terminate an employee for any or no reason, is in force.
Despite its reliance on manufacturing, Indiana has been much less affected by declines in traditional rust belt manufactures than many of its neighbors. According to the Bureau of Labor Statistics, Indiana is one of very few states where the unemployment rate declined from March 2009 to March 2010 (10.1 vs. 9.9%). The explanation appears to be certain factors in the labor market. First, much of the heavy manufacturing, such as industrial machinery and steel, requires highly skilled labor, and firms are often willing to locate where hard-to-train skills already exist. Second, Indiana's labor force is located primarily in medium-sized and smaller cities rather than in very large and expensive metropolises. This makes it possible for firms to offer somewhat lower wages for these skills than would normally be paid. Firms often see in Indiana a chance to obtain higher than average skills at lower than average wages.

Indiana is home to the international headquarters of pharmaceutical company Eli Lilly in Indianapolis, the state's largest corporation, as well as the world headquarters of Mead Johnson Nutritionals in Evansville. Overall, Indiana ranks fifth among all the states in total sales and shipments of pharmaceutical products and second highest in the number of biopharmaceutical related jobs.

Indiana is located within the U.S. corn and grain belts. The state has a feedlot-style system raising corn to fatten hogs and cattle. Along with corn, soybeans are also a major cash crop. Indiana's proximity to large urban centers, like Chicago and Indianapolis, supports dairying, egg production, and specialty horticulture. Other crops include melons, tomatoes, grapes, mint, popping corn, and tobacco in the southern counties.

Poverty
For all age groups, Indiana has less people living in poverty than the nation as a whole. However, Indiana has slightly more children than the nation as a whole who live in households lower than 100% of the Federal Poverty Level. Additionally, Indiana's median income, $50,303 is below the national average. (www.statehealthfacts.org)

In terms of poverty rate by race/ethnicity, Indiana's black population is significantly more affected by poverty than the rest of the black population in the United States. The black population living in Indiana is almost three times more likely to suffer from poverty. According to a 2007 GAO report titled, POVERTY IN AMERICA: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions As Well As the Economic Growth Rate, economic research suggests that individuals living in poverty face an increased risk of adverse outcomes, such as poor health and criminal activity, both of which may lead to reduced participation in the labor market. While the mechanisms by which poverty affects health are complex, some research suggests that adverse health outcomes can be due, in part, to limited access to health care as well as greater exposure to environmental hazards and engaging in risky behaviors.

Additionally, exposure to higher levels of air pollution from living in urban areas close to highways can lead to acute health conditions. Data suggest that engaging in risky behaviors, such as tobacco and alcohol use, a sedentary life-style, and a low consumption of nutritional foods, can account for some health disparities between lower and upper income groups.

The relationship between poverty and adverse outcomes for individuals is complex, in part because most variables, like health status, can be both a cause and a result of poverty. These adverse outcomes affect individuals in many ways, including limiting the development of skills, abilities, knowledge, and habits necessary to fully participate in the labor force.

Low-income children are less likely to be covered by healthcare and thus are more likely to lack primary care and other necessary medical services. Because of these disparities, providing services to children from low-income households is of paramount concern for our nation and has led to national coverage programs for children. Healthcare financing sources for low-income and disabled children include Medicaid and SCHIP funding, administered in Indiana through Hoosier

Healthwise which includes a risk-based managed care (RBMC) program, Care Select for aged, blind, disabled, and other special populations, and fee-for service Medicaid programs.

According to information compiled by Covering Kids and Families (CKF) in Indiana, there are 1,680,000 children under the age of 19 in Indiana. Of these children, about one in 10 (or 161,000) has no health insurance.
• Indiana ranked 35th in the nation in 2006 for the number of children living in poverty.
• 95.3% of Indiana's uninsured children are members of working families. (Families USA)
• In 2007, 7% of Indiana's children under the age of 6 were uninsured.
• In 2007, 8% of Indiana's children between the ages of 6 and 12 were uninsured; 14% of children between the ages of 13 and 18 were uninsured.
• 48.2% of Indiana's uninsured children live in families with annual incomes at or below twice the federal poverty level (Families USA 2008)
• Indiana had the highest per capita rate of individual medical bankruptcies in the nation in 2006.
• From 1999 to 2005, Indiana had the nation's highest percentage drop in workers who receive employer-sponsored health insurance.

At the Governor's direction, Indiana is working diligently to improve the economic status of Hoosier children and their families.

Racial/Ethnic Disparity
Like the rest of the United States, Indiana is growing more diverse culturally, racially, and ethnically. This change will continue to increase over the coming years and will enrich Indiana as a state and help to expand its global perspective. However, while there are many positive outcomes due to this growth, there are also problems, such as inadequate health delivery.

The National Institutes of Health states that "Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the US." It is racial and ethnic minorities that are facing a disproportionately greater burden of disease, injury, premature death, and disability. Indiana's MCH and CSHCS programs are aware of racial and ethnic health disparities in Indiana and are working to impact the many contributing factors that influence an individual's health. These factors include but are not limited to the environment, lifestyle choices, cultural beliefs, poverty, past experiences, insurance status, and employment. Additionally, racial and ethnic minorities also experience barriers to health including access to care; limited English proficiency; no continual source of health care; limited health education; racial and ethnic assumptions; and lack of diverse employment skills.

Reducing health disparities among racial and ethnic groups in Indiana requires the cooperation of legislators, governments (both local and state), providers of health care, and the community. Improved data collection, better access to care, essential preventative care, and community involvement are also necessary to improve current health status and conditions of all racial and ethnic minority groups.

Minority, racial, and ethnic populations in Indiana make up more than 15% of the current population. Overall, blacks have the highest age-adjusted death rates, followed by whites and Hispanics.

In Indiana, the black non-Hispanic population consistently has more severe health outcomes than the white non-Hispanic population. The infant mortality rate for black non-Hispanic is about two and a half times that of the white non-Hispanic population. The percentage of low birth weight infants for black non-Hispanics is nearly double that of the white non-Hispanic infants. The percentage of black non-Hispanic and Hispanic mothers who received adequate prenatal care or who received prenatal care in the first trimester is much lower than the white non-Hispanic mothers. The percentage of mothers receiving late or no prenatal care is much higher for black non-Hispanic and Hispanic mothers compared to white non-Hispanic mothers. The percent of

black non-Hispanic mothers who initiated breastfeeding is well below that of the white non-Hispanic mothers.

This information has helped to guide the development of the newly revised State Performance Measures and will be used to determine the judicious allocation of scarce Title V resources.

Geography
In Indiana, 70% of the population lives in a metropolitan area while 30% lives in a rural area. According to the Indiana Rural Health Association, rural communities have higher rates of chronic illness and disability and poorer overall health status than urban communities. Rural residents tend to be older and poorer than urban residents. Eighteen percent of rural residents are over 65 compared to 15 % of urban residents and more rural residents live below the poverty level compared to urban residents.

Chronic conditions such as heart disease and diabetes are more prevalent in rural areas. Injury-related deaths are 40% higher in rural communities than in urban communities. Cancer rates are higher in rural areas. People living in rural areas are less likely to use preventive screening services, exercise regularly, or wear safety belts. These disparities among rural and urban Hoosiers may be caused by a number of reasons including:

Transportation--Many individuals lack access to treatment because appropriate transportation is too expensive, limited by weather factors, or because the patient is too sick to use the options that are available.

Lack of Providers --Residents of rural areas have less contact and fewer visits with physicians. Although 20 % of Americans live in rural areas, only 9 % of the nation's physicians practice in rural areas and only 10 % of specialists practice in rural areas. In addition, 81% of urban counties and 98% of rural counties in Indiana fail to meet the national benchmark for an adequate ratio of primary care specialists per 100,000 population that affects services to children with special healthcare needs. There are 6,000 unfilled nurse positions in our hospitals. Both urban counties (65%) and rural counties (87%) fail to meet the U.S. benchmark for an adequate ratio of RNs per 100,000 population. Indiana has a shortage of 1000 primary care physicians. If current trends continue, we will need almost 2,000 additional primary care physicians and 20,000 registered nurses (RNs) in Indiana by 2020.

Lack of Services-- Nationally, many rural hospitals have negative operating margins and, from 1984 to 1997, over 500 rural hospitals closed. Several counties in Indiana, such as Pike and Crawford counties in southwest Indiana, do not have a hospital and a number of areas in Indiana have limited or no trauma services at all. In west central Indiana (this geographic area includes Indiana to the Illinois state line on the west, Lebanon on the north, Sullivan on the south, and Bloomington/Indianapolis is on the east), Hoosiers have to travel more than 50 miles to a trauma center.

Limited Services--Rural residents are more likely to report that their provider does not have office hours at night or on weekends.

Insurance--One national study found that almost 20 % of rural residents were uninsured compared with 16 % of urban residents. Rural residents under 65 are disproportionately uninsured. According to the National Association of Community Health Centers, Indiana had 18 Federally Qualified Health Centers (FQHC) and 86 delivery sites in 2008. These FQHCs saw a total number of 218,738 patients seen in 2008. Of those patients, 4,526 were migrant/seasonal workers and 8,810 were homeless. On average, 42% of clients were uninsured, 40% had Medicaid and 5% were Medicare clients. Twenty-nine percent resided in a rural area.

Urbanization
Since the 2000 Census, the population has increased 7.2 % in the U.S. and 4.4 % in Indiana.

Within Indiana, metropolitan areas experienced population gains, while other areas experienced population declines. The fastest growth during both time periods was in the Indianapolis metropolitan area. (Urban Institute and Kaiser Commission on Medicaid and the Uninsured)

Urbanization can have a serious impact on health and many of the negative impacts are suffered by the poor and minorities in greater disproportion. Urbanization is associated with changes in diet and exercise that increase the prevalence of obesity with increased risks of Type II diabetes and cardiovascular disease; vulnerability to sexual abuse and exploitation; and separation from social support networks. Many of these conditions affect the most vulnerable segment of the population - women, children and the elderly.

Environmental contaminants, although not restricted to urban settings, can alter the reproductive process and increase the risk of abortion, birth defects, fetal growth and perinatal death. Particularly in cities, motor vehicles are an important source of air pollution and studies in Indiana are associating pesticides in water with poor birth outcomes. Children are especially susceptible to disease in an urban environment. Not only can they suffer from overcrowding, poor hygiene, excessive noise, and a lack of space for recreation and study, they also suffer from stress and violence that such environments create.

Many of the ill effects of urban life affect people from all incomes. Although most people living in the city take basic public services such as drinking water supply, housing, waste disposal, transportation, and health care for granted, these services are often either deficient or nonexistent for the poor.

Private Sector Title V Service Delivery Challenges
The three private sector challenges in providing Title V services are (1) lack of providers who accept Medicaid reimbursement, (2) lack of cultural competency, and (3) location of services.

Medicaid Providers -- Indiana has a risk based managed care system for all MCH populations on Medicaid. Providers in some counties have refused to participate in Medicaid reimbursement for pregnancy and infant care until the infants are on CHIP. These counties tend to have poorer pregnancy outcomes.

A serious challenge in Indiana over the past few years is not only the number of physicians who do not accept Medicaid reimbursement but also a flawed Medicaid enrollment system that has left many eligible women and infants without insurance coverage throughout the pregnancy and critical first few months of age. In an effort to overcome enrollment challenges for pregnant women, Indiana Medicaid began Presumptive Eligibility (PE) on July 1, 2009. Even so, there are areas of the state where providers are less likely to accept Medicaid reimbursement. Of 92 counties, five have no providers participating in Presumptive Eligibility. Due to the small numbers of prenatal care providers participating in presumptive eligibility, twenty-two (22) counties have lower numbers of pregnant women enrolling in prenatal care.

Lack of Cultural Competency -- Lack of cultural competency has played a role in driving black-to-white perinatal disparities higher. In 2006, three counties had a black infant mortality rate greater than 30 per 1,000, approaching third-world statistics. MCH is targeting 5 counties in Indiana that have 80% of the black population and the highest disparity issues. MCH has worked with these counties to increase the cultural competency knowledge of providers and funded programs to address disparate issues.

To address these disparities, MCH is utilizing a life course perspective to impact change. For Indiana to make a difference in black disparities, MCH must work at the neighborhood level to educate and empower high risk populations that encounter cultural barriers to equitable health care services. MCH has been collaborating with the ISDH Office of Minority Health, the Indiana Minority Health Coalition (IMHC), and local minority health coalitions in the five disparity counties. The Indiana Perinatal Network (IPN) and the IMHC both provide agency cultural competency

training.

Immigrant populations are also facing barriers to healthcare. An increasing Hispanic population is facing barriers to care from lack of insurance, interpreters, and educational materials and forms that are translated into Spanish. Hispanic centers around the state do not have the capacity to assist all Hispanic families in need.

Indiana also has the largest Burmese population outside of Burma than anywhere else in world. While there are services in place to help this population, they may not be adequate to ensure the Burmese have access to culturally appropriate healthcare services.

Location of Services -- Indiana's counties are all autonomous. Efforts in the past to regionalize health systems were not accepted. This has led to lack of accessible services for all Title V populations. The majority of Indiana's primary care physicians are located within 5 counties. Seventeen counties are without a hospital. The only two specialty children's hospitals are both located in Marion County (Indianapolis). Families in some parts of the state must travel long distances to receive specialty care during pregnancy and for children. A large population of pregnant women and children seek health care services in four neighboring states -- Illinois, Ohio, Kentucky and Michigan. Service in the State of Indiana may improve because three large healthcare systems in Indianapolis are buying hospitals around state and providing an increase in services in some counties. MCH will address regionalization of hospitals providing perinatal services over the next five years.

Current and Emerging Issues
In terms of MCH, an overriding issue is the effectiveness of our interventions and programs. Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this phenomenon, it is an issue that we are in the process of addressing. First, we have renewed our commitment to improve the health and well being of mothers, children, and women of childbearing ages. Second, we have rethought our strategies and are focusing on evidence-based interventions. Third, we are defining and implementing a life course health perspective and intend to partner with many more providers and communities to make a difference. With a fresh eye and renewed energy, we are moving in a new and exciting direction.

From our five year needs assessment, we have identified 10 top State priority issues -- two are continuing, three have been modified, and five are new. The following paragraphs provide a brief overview of these issues. More discussion on these issues can be found in the State Performance Measures and the Five Year Needs Assessment.

Pregnancies occurring at short interval are an important issue because they increase the risk for adverse outcomes such as low/very low birth weight babies, premature births, and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to increase opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns.

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions, initiation of a recognition program acknowledging Baby Friendly Hospitals, and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers.

Two problems concerning infants require a special focus: (1) prematurity rates, and (2) accidental suffocation under one year of age. Although premature birth rates are approximately at the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Steering Committee, which is driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will also include communication of safe sleep practices, updates to nurse managers/nursing staff, and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network (IPN), and local community organizations in the four largest counties to conduct training and educational sessions.

Concerns involving children and adolescents involve lead poisoning, sexually transmitted infections (STIs), obesity, and social-emotional heath of very young children. Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and work with Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated. Reduction in the number of STIs is another state objective. Strategies to reduce the STI numbers include providing education and materials to providers treating adolescents, conducting a needs assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Family Health Council to increase screening for STIs.

Obesity in high school age children is also a state concern. Recent data indicates that 13.8% of youth have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks, and increased physical activity.

Addressing issues pertaining to the social-emotional health of children under the age of 5 is also an initiative. Foremost among these issues is the lack of qualified service providers to treat children is this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refuges/immigrants, and children of deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area.

The CSHCS division will be focusing its efforts with families and other partners in two main areas. First, the mission of the Integrated Community Services (ICS) Program started in 2008 within the division of Children's Special Health Care Services (CSHCS) is to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. This is a new initiative for the Indiana CSHCN program that has traditionally concentrated on reimbursing medical services for children with specific chronic conditions. Indiana was one of six states to be awarded federal funding from HRSA/MCHB to support system improvement for CYSHCN and their families and began working on systems improvement on June 1. 2009. Indiana is addressing objectives that fill gaps for CYSHCN in Indiana in each of the six core outcomes of successful systems of care for CYSHCN while synthesizing the goals into "umbrella" or overarching goals focused on 1) Medical Home Implementation, 2) Transition to Adult Care, and 3)The Indiana Community Integrated Systems of Services (IN CISS) Advisory Committee development in order to sustain the project.

The second emerging area of focus involves Indiana's CSHCS program reimbursement of providers for direct service expenses related to the CSHCS participants' medical condition. With the present economic climate the program faces continuing challenges to provide the past level of

benefits within the current budget constraints.

B. Agency Capacity

In terms of services during the fiscal year 2010, MCH was able to use Title V grant money to fund 12 family planning projects; five genetics centers (providing information, education and services to families of children with genetic disorders or birth defects); 11 infant health projects (providing primary, direct care services to children from birth to less than one year of age); nine prenatal care clinics (providing direct pre-natal medical care by an OB provider), 11 child health clinics (providing direct medical health services to children); six sites provide adolescent health services (three of them are school based providing direct health care services, education and referrals to high school students); one high risk infant follow-up program (providing follow-up care to newborns who were diagnosed with neurological or developmental problems); 15 prenatal care coordination (providing in-home visiting program to high risk pregnant women); six prenatal substance use prevention programs (providing high risk, chemically dependent pregnant women with education, referrals for treatment, and follow-up); six family care coordination programs (providing assessments, education, referrals, and advocating for families); and four dental projects. The narrative that follows provides some insight into the extensive partnership system that helps to ensure services, at all pyramid levels, to the Title V populations. (Please refer to Section B.2 of the Five Year Needs Assessment for a full listing of all partnerships.)

State Program Collaboration with Other State Agencies and Private Organizations

Collaboration with other state agencies and private organizations is key to continued capacity building to meet the needs of the Title V populations. At the State level, at least two agency partnerships have been pivotal in meeting the needs of the Title V population. These include the Family & Social Services Administration (FSSA) and Department of Education (DOE). Under FSSA, the Office of Medicaid Planning & Policy (OMPP) assists not only with payment issues but also with protocol and policy issues that help to establish uniformity and quality of care for women of childbearing age, pregnant women, children, and children with special needs. Collaboration with the DOE ensures that the needs of children/children with special needs are met in the educational venue. The partnership with DOE also provides an entryway for educational curricula on public health issues such as HIV/AIDS, STIs, and fetal alcohol spectrum disorders.

Partnerships with private organizations provide a mechanism for growing capacity beyond the reaches of government. Especially important are the partnerships with professional organizations in the healthcare industry. Examples include the American Academy of Pediatrics (Indiana Chapter) and the Indiana Academy of Family Physicians, which have been key partners in the Community Integrated Systems of Services project. The Indiana chapter of the American College of Obstetricians and Gynecologists and Indiana Certified Nurse Midwives assist in creation and implementation of prenatal standards of care as well as participating on initiatives such as decreasing prematurity. Organizations, such as the Indiana Perinatal Network and the Indiana Chapter of March of Dimes, are also instrumental in bringing issues on health/healthcare for the Title V populations to the legislative forefront, and disseminating perinatal health information throughout the state.

State Support for Communities

Limited staff at the State level means that resources must be used in a judicious manner to support the local communities. Dedicated State staff serve as a focal point or clearing house, providing local communities with information and research on evidence-based protocols and best practices. Since staff at the State level are aware of a wide range of programs across the state, Title V staff members also provide a means of connectivity between projects. This connectivity allows the sharing of information concerning successes and challenges in the implementation of a variety of local programs.

One example of an interface with local programs is the prenatal care coordination (PNCC) program. This program develops and coordinates access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. The PNCC project provides outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients.

One further example of state and local collaboration is the Early Hearing Detection and Intervention (EHDI) project. EHDI screens newborns for possible hearing impairment. Any infants testing positive for hearing impairment receive early intervention services. EHDI coordinates with Indiana First Steps, hospitals, providers, and other local agencies to provide intervention and follow-up services.

MCH also funds the Indiana Family Help Line (IFHL) which provides a means of connecting families with community level services. For example, during calendar year 2009, the top five needs were dental, transportation, food & clothing, health/medical, and financial assistance, respectively. A strong relationship between MCH staff and MCH clinic directors also allows for a sharing of information concerning local participation in community programs such as school wellness projects.

Coordination with Health Components of Community-Based Systems

Key health components in community systems include access to care, insurance coverage, prevention initiatives, and a medical home for children with special needs. At the state level, MCH and CSHCS collaborate with the OMPP, in the Indiana FSSA, to ensure a woman's access to prenatal care via the "presumptive eligibility" program. Children's Special Health Care Services (CSHCS) also collaborates with OMPP to provide supplemental medical coverage to families of children with chronic medical conditions. Community-based staff provide feedback to MCH staff concerning strengths and issues associated with these processes. Prevention programs are a key component in addressing issues, especially those associated with pregnancy. Examples of such initiatives include smoking cessation during pregnancy and prematurity prevention. IPN and the Coalition to Prevent Smoking in Pregnancy (CPSP) are two examples of organizations that provide a conduit between state and local advocates in support of these initiatives.

The medical home is an especially important component for children/children with special needs. Currently, the pediatric staff at Indiana University School of Medicine is working with the Community Integrated System of Services on the medical home learning collaborative. This collaborative involves 9 pediatric and family practice members and is charged with establishing medical homes in these practices and others.

Coordination of Health Services with Other Services at the Community Level

Indiana has at least two major mechanisms to coordinate health services with other community services. The IFHL is a centralized clearing house which connects families with services located in their respective counties/communities on a statewide basis. IFHL participates in the Indiana 211 Partnership, a regionalized information and referral service. IFHL is also involved with Connect2Help which provides a forum for discussion/implementation of standards, resources and policies concerning information and referral systems. The second mechanism of coordination of services concerns the contractual agreement with each of the MCH clinics providing services. Inclusion of Memorandums of Understanding (MOUs) with community organizations providing support services is strongly encouraged and reviewed with each clinic grant application.

State Statutes Related to Title V Authority

In terms of state statutes, the following summaries present the most recent legislation that affects the Title V populations.

Newborn Screening Law (IC 16-41-17) -- Requires screening for 44 genetic and metabolic conditions.

Universal Newborn Hearing Screening (IC 16-41-17-2) -- Requires newborn hearing screening prior to infants leaving the hospital. This statute also requires appropriate referrals for confirmed positive test results.

Birth Defect Information (IC 16-38-4 and rule 410 IAC 21-3) -- Requires the collection and maintenance of birth defect information. This provides for the creation and support of the Indiana Birth Defects and Problems Registry.

Funding for Children with Special Health Care Needs (IC 16-35-2 and IC 16-35-4) -- Requires provision for and distribution of funds for children with special health care needs.

Workplace Lactation Support (SEA 219; P.L.13-2008) -- Requires government and private employers to provide a private space and access to cold storage for women to express breast milk while at work.

Tobacco Warning During Pregnancy (HEA 1118; P.L. 94-2008) -- Requires all retail outlets that sell tobacco products to post a warning of the dangers of smoking during pregnancy and post the toll-free Indiana Quitline number.

Family Planning Waiver (SEA 572; P.L. 20-2005) -- Requires the OMPP to submit a waiver to the federal government extending Medicaid coverage for up to two years postpartum for family planning services.

Prenatal Substance Use Report (HEA 1314; P.L. 86-2006)--Requires the ISDH to assess the incidence and factors associate with substance abuse use during pregnancy in the State of Indiana.

Prenatal Substance Use Commission (HEA 1457; P.L. 193-2007) -- Establishes a statewide, multi-agency, bi-partisan commission to make recommendation on how to reduce substance use during pregnancy in the State of Indiana.

Cigarette Tax Increase (HEA 1678; P.L. 218-2007) -- Increases the tax on cigarettes and designate funds to support smoking-cessation activities, covering uninsured individuals and immunizations.

Other legislative activities include efforts to implement a smoking ban in public places; however, this effort failed. One highlight in tobacco-related legislation involved the failed attempt to abolish the Indiana Tobacco Prevention and Cessation Agency's Executive Board, dissolve the agency, and transfer the assets of the ITPC to the ISDH a part of SB 298.

As reported in the Indianapolis Star (3/23/10), Governor Daniels suspended future enrollments for childless adults in the Healthy Indiana Plan, blaming the healthcare reform package passed by Congress. Daniels said the state should continue to enroll families for the immediate future so it would not be forced to forfeit federal stimulus dollars.

Based on Senate Act 226, the health finance commission is studying the topic of teen suicide, including the root causes and prevention, during the 2010 legislative session. Finally, House enrolled Act 1320, which controls the selling and purchase of ephedrine and pseudoephedrine, also requires the legislative council to assign study topics on this issue. It was signed into law by Governor Daniels on 3/18/10.

State Title V Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants

MCH and CSHCS are committed to providing quality, comprehensive, holistic health care to low-income pregnant women, mothers and infants in community settings and decreasing infant mortality and low birth weight babies. In FY 2010-2011, Indiana Title V funded 36 direct care services in 24 counties. These direct care services provided care to 26,016 pregnant women, 89,607 infants, 73,030 children 1 to 22 years of age, and 6,551 children with special health care needs.

MCH provides the "Free Pregnancy Test Program", a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The program also helps pregnant women obtain early prenatal care through Hoosier Healthwise, WIC, and prenatal care coordination. Furthermore, it assists the entrance of non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Currently, Free Pregnancy Test program is in 58 counties and served 14,382 clients in FY 2009.

MCH provides enabling services for pregnant women, mothers and infants through grants to five prenatal care coordination programs. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women. The program targets pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCH staff also oversees the training and certification of community health workers to assist prenatal care coordinators.

MCH supports pyramid level enabling services for smoking, alcohol and drug use cessation in the Prenatal Substance Use Prevention Program (PSUPP). MCH receives money from the State's Division of Mental Health and Addiction (DMHA) to fund all or part of eight of the grantees, Tobacco Settlement funds three grantees and Title V funds all or part of five grantees, including one site that receives partial funding from both Title V and DMHA.

Preventative and Primary Care Services for Children

MCH provides preventative and primary care for children through grants to 11 child health care clinics and 6 adolescent health care clinics. These clinics provide both direct medical and enabling services. Many of these grantees are community health centers or are a part of a larger health care facility. MCH provides additional enabling services through six family care coordination programs. Family care coordinators are trained professionals who make home visits to coordinate services for high risk families. In addition coordinators provide referrals, education, and support.

Children's Special Health Care Services (CSHCS)

Indiana's CSHCS provides supplemental medical coverage to help families of children who have serious, chronic medical conditions, age birth to 21 years of age. The program serves families with an income before taxes no greater than 250% of the federal poverty level. Statewide partnerships include family support organizations, Medicaid, hospitals and providers of medical services. CSHCS has gone from covering a few diagnoses to providing coverage for well over a thousand specific conditions. The caseload has grown from the original 12 to more than 8,500 participants.

The Integrated Community Services (ICS) Program focuses on building collaborative relationships with agencies and organizations to integrate family-centered and culturally competent service systems for Children and Youth with Special Healthcare Needs (CYSHCN). The ICS Program was awarded a three year (6/1/2009-5/31/2012) HRSA grant to improve access

to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families.

The Indiana Community Integrated Systems of Services (IN CISS) Project is focused on three primary objectives including (1) implementing Medical Homes within primary care practices throughout the State; (2) transitioning youth with special healthcare needs to adult healthcare, work and independence, and (3) building systems sustainability through the organization of a Statewide Advisory Committee representing CYSHCN, their families, and the organizations that serve them.

ICS partnerships include CYSHCN and their families, family support organizations, Indiana American Academy of Pediatrics (AAP), Indiana Academy of Family Phsycians(AFP), governmental, State and local agencies, medical professionals/providers, medical institutions and local communities.

Core partners include (1) the IU School of Medicine (IUSOM)that provides a project facilitator, parent consultants, and project evaluator, (2) the Center for Youth and Adults with Conditions of Childhood (CYACC) that provides a website and educational office visits to help youth with specials healthcare needs transition to adult healthcare, and (3) About Special Kids (ASK) that provides meeting support and stipends for families and youth.

To enhance the capacity of CSHCS to access family-centered, community based coordinated care, the IN CISS project has recruited nine healthcare practices to participate in a medical home learning collaborative. This project is aiding the nine practices in developing and implementing quality improvement efforts. Teams are participating in biweekly teleconferences and face-to-face site visits. A face-to-face kick-off meeting was held in October 2009 and a follow-up large group meeting was held in May 2010.

Cultural Competence

In an effort to address health disparities in Indiana, the General Assembly passed legislation creating the Indiana Council on Black and Minority Health (IC 16-46-6 1992) and directed ISDH to create an Interagency Council on Black and Minority Health. This council includes representation from both government and State agencies. According to the Interagency Council on Black and Minority Health's Report for 2008, some of the key issues in minority health include teen pregnancy and entrance into prenatal care in the first trimester. The teen pregnancy rate is significantly higher for minorities and the percentage of minorities who have early entry into prenatal care is much lower than whites.

MCH staff work with the Director of the Office of Minority Health and the Minority Health Epidemiologist on disparity issues such as prematurity, low birth weight, very low birth weight, and infant mortality. MCH also encourages all grantees, especially those in areas with large or growing minority populations, to work with local Minority Health Coalitions to develop culturally competent staff and materials.

MCH funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Training in cultural competency is provided by one of MCH's grantees, IPN, on an as requested basis.

The Indiana Minority Health Coalition (IMHC) director serves on the Steering Committee of Core Partners for Early Childhood Comprehensive Systems (ECCS) initiative. IMCH also participates in programs such as "Have a Healthy Baby", "Operation Fit Kids", and "Diabetes Self Management".

MCH also collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort

Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meetings, and work with faith based organizations. Specifically, MCH will reach out to the Minority Health Coalitions this year, especially those coalitions in the counties with the highest infant mortality disparity. We have begun discussion with coalitions in the four counties listed above and are planning a summit to develop action plans to reduce infant mortality in these counties which have statistics that rival some third-world countries. (Please refer to section B.3 of the Five Year needs Assessment.)

MCH has shared the 'Unnatural Causes' series information with local minority health coalitions and has encouraged them to show the series in local neighborhoods and faith-based organizations. The 'Unnatural Causes' videos have been shown at county summits in Lake County and Marion County. Each September (Infant Mortality Month), MCH creates a display in lobby of the ISDH with facts and resources about health disparities in Indiana's black population and shows the 'Unnatural Causes' videos to ISDH staff during a series of lunch and learns. The Marion County Health Department (MCHD) has shown the series to their MCH staff.

Disparity figures and GIS maps for the five targeted disparity counties have been shared at county meetings and hospital grand rounds. The IUSOM recently conducted an obstetric grand round on the life course perspective and cultural competency. MCH also shares life course information, disparity information, and educational materials, including "A Healthy Baby Begins with You" at the Indiana Black Expo every year.

C. Organizational Structure

The Honorable Mitchell (Mitch) E. Daniels, Jr. (R) was sworn in January 2005 as Indiana's 49th Governor. The Governor was re-elected for his second and final term in November 2008. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head ISDH. She led the Health Department until her resignation in March 2010 to take a position at the Centers for Disease Control as the Deputy Director and Director of the new Office of State, Tribal, Local and Territorial Support.

The new State Health Commissioner, Dr. Gregory N. Larkin, M.D., FAAFP, was appointed by Governor Daniels as the Indiana State Health Commissioner in March 2010. At that time, he was asked by the Governor to continue the State's progress in immunizing children, reporting and reducing medical errors, and improving the health culture of Indiana. Prior to his appointment, Dr. Larkin, and served as the Chief Medical Officer for the Indiana Health Information Exchange, which promotes health information technology for the advancement of quality patient and community care. He is a recognized leader in the promotion of health information and technology and will extend Indiana's recognized preeminence in that area. Before joining the Indiana Health Information Exchange as its Chief Medical Officer, Dr. Larkin was the Director of Corporate Health Services for Eli Lilly and Company. During his tenure at Eli Lilly, Dr. Larkin was the company's Global Medical Director managing five domestic health care clinics, the domestic employee and retiree health plan and was the global liaison for the company's world affiliates for occupational and corporate health care. He has been a member of the Healthy Indiana Plan task force, served as Chairman of the Board of the Indianapolis Medical Society and the Indiana Blood Center, and volunteered with many other medical and community organizations.

ISDH is one of several major agencies in State government. ISDH has five commissions overseen by the State Health Commissioner and Deputy Health Commissioner (Please refer to the attached organizational chart). Loren Robertson M.S., R.E.H.S. was appointed Deputy Commissioner in June 2009. Prior to his appointment, Loren served as the Assistant Commissioner for Public Health and Preparedness at ISDH. For more than 30 years, he was associated with the Ft. Wayne - Allen County Department of Health before he began his career with ISDH in May 2005.

The five commissions at the ISDH include Laboratory Services, Public Health and Preparedness, Operational Services, Health Care Quality and Regulatory, and Health and Human Services, which is where the Title V Program resides. As of June 2010, Dawn Adams is the Interim Assistant Commissioner of the Health and Human Services (HHS) Commission. HHS includes the Office of Women's Health, Nutrition and Physical Activity, WIC, Chronic Disease, Children's Special Health Care Services (CSHCS) and Maternal and Child Health (MCH). MCH and CSHCS are responsible for administering and coordinating all parts of the Title V Block Grant for Indiana.

Dawn M. Adams, J.D., has been with ISDH since 2006 and currently serves as the Interim Assistant Commissioner of the Health and Human Services Commission. She was hired as a Staff Attorney in the Office of Legal Affairs and was recruited by the former Assistant Commissioner of the Public Health and Preparedness Commission, Loren Robertson, to serve as his Operations Manager in the fall of 2008. Her work with public health began in 1993 when she worked as an Environmental Health Specialist for the Grant County Health Department. As the Operations Manager, Ms. Adams took on special projects and served as a resource to the division directors for all things "operational" (finances, contracts, legal issues, human resources, IT, etc.). In addition to these duties, she serves as the Preventive Health and Health Services Block Grant Coordinator on behalf of the agency and frequently takes on other special assignments as requested by the Deputy State Health Commissioner.

Judith A. Ganser, M.D., M.P.H. is Medical Director for Maternal and Child Health, Children's Special Health Care Services and WIC at ISDH. In this position, she is responsible for providing public health leadership, policy development, and medical guidance to programs including prenatal, child and adolescent health, CSHCS, Genomics Program, PSUPP, Indiana RESPECT teen pregnancy prevention, WIC, Early Childhood Comprehensive System planning and Community Integrated Systems of Service for children with special health care needs (CSHCN). She works with a multidisciplinary professional team and administrative staff. Dr. Ganser received her medical degree from Temple University Medical School and her Masters in Public Health from the University of North Carolina at Chapel Hill. She is board certified in Pediatrics and did a Preventive Medicine residency. Prior to joining ISDH in 1991, she served five years as the Medical Director of the Adolescent Health Program for MCHD. She has also worked as a Pediatrician in a Community Health Center in Pueblo, Colorado and Physician-team leader in School-Based Pediatric/Adolescent Clinics in Dallas, Texas.

In the Health and Human Services Commission, Mary M. Weber, MSN, RN, NEA-BC, became the new Director of the Maternal & Child Health Division in October 2009. Kimberly Minniear became the new Director of CSHCS in February 2010, after serving as the Director of Integrated Community Services since May 2007. Also, in April 2010, James R. Miller, DDS was hired as the Director of Oral Health.

Mary Weber, MSN, RN, NEA-BC, joined ISDH as the Director of the Division of Maternal and Child Health in October of 2009. Prior to joining ISDH, Ms. Weber served in leadership roles related to maternal and child health for over twenty years in both for-profit and not-for-profit corporations. Most recently, she was the administrator for Women's Health for the Clarian Health System in Indiana, responsible for strategic planning, program development, labor management, and overall operational administration. Specific programs included perinatal outreach, childbirth education, Clarian Breastfeeding Center, perinatal bereavement, postpartum home visits, postpartum mood disorders, support groups for mothers of infants and toddlers, and an interpreter-doula program for Spanish speaking maternity patients.

Ms. Weber has been active on many volunteer boards, including IPN, the Indiana University National Center of Excellence for Women's Health, and the Indiana Mothers' Milk Bank, and CKF. She led the effort to establish the Indiana Mothers' Milk Bank, which pasteurizes human milk from screened donors and distributes it to newborn intensive care units throughout the Midwest. Ms. Weber received her Master's degree in Nursing Administration from Indiana University School of

Nursing, and is board certified as a Nurse Executive Advanced.

Kimberly K. Minniear is the Director of the Children's Special Health Care Services (CSHCS) Division. With a BA from Indiana University in Social and Behavioral Sciences, she received the honor of the 2004 Marion County Social Worker of the Year. Ms. Minniear's professional experience includes serving for seven years as a Marion County Family Case Manager at the Department of Child Services, for two years as the Executive Director for the Kokomo Academy in Kokomo, IN., and for five years as the Executive Director of the Carroll County Department of Family & Social Services in Delphi, IN. Among her many accomplishments, Ms. Minniear developed treatment programming for a new juvenile male residential treatment; wrote grants, secured funding, and established Peer Counseling Program for children; developed programs to enhance parenting skills for at-risk families; served as a member of the Child Protective Team; and is a Certified Child Protective Social Worker.

Dr. Jim Miller joined the HHS Commission as the Oral Health Director in April 2010. He has over twenty-five years combined experience in teaching, practice, and dental public health research. He holds D.D.S. and M.S.D. degrees from the Indiana University School of Dentistry, and was a Senior Fellow for five years in the Department of Dental Public Health Sciences at the University Of Washington School Of Dentistry. He also holds a Ph.D. degree in Epidemiology from the University of Washington.

Although not housed in the same commission, MCH works closely with the Office of Primary Care, Lead and Healthy Homes, HIV/STI, Public Health and Preparedness, Immunization, and the Epidemiology Resource Center which are housed in the ISDH Public Health and Preparedness Commission. MCH programs and staff also work closely with the ISDH Operational Services Commission for Finance, Information Technology, (HIPAA) Compliance, Public Affairs, the Office of Minority Health, Legal (and Legislative) Affairs, and Vital Records.

Title V Program Administration

MCH distributes the Title V Federal-State Block Grant Partnership budget primarily through grants to community agencies that provide direct, enabling, population-based, and infrastructure building services that impact the federal and State performance measures.

MCH Business and Grants Management staff manages all contracts, grants, MOUs and MOAs, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures for the MCH Division and the CSHCS Division. This section makes Title V budget and planning recommendations and coordinates all applications for funding, including primary responsibility of preparing Title V Budget and Budget Narrative and Budget. The staffs coordinate all contracting, procurement and programmatic financial tracking and provide clerical support for the MCH Division. Since July 2007, Vanessa Daniels, MPA, MRC, CRC, has managed this Section.

An attachment is included in this section.

D. Other MCH Capacity

Title V funds enable 86 full-time employees and 34 contractors (16 part-time and 18 full-time for MCH and CSHCS). Title V funds also support one dentist and one secretary in the Oral Health Program, one Information Technology Service (ITS)professional, and two contractual positions in ITS. Outside the HHS Commission, Title V funds support the following staff: one Director, two Environmental Scientists, one Administrative Assistant and one Data Processing Operator for Indiana Lead and Healthy Homes; one Chemist for LRC Chemistry Lab; and four fluoridation staff which include two General Sanitarians, and two Fluoridation Consultants.

Mary Ann Galloway joined the MCH Division on April 19th as the Director of Life Course Health

Systems. Ms. Galloway has an MPH from the University of South Carolina and received a PMP certification in 2006. She established and directed the Project Management Office at MPlan, a large health care insurer in Indiana, for three years. Prior to that engagement, she founded and directed a national consulting firm for over 20 years that specialized in healthcare system delivery development, project management and managed healthcare. Her company worked with primary care and other providers in over 20 states who served mothers, infants and children. She manages a team of seven Life Course Health Systems staff. The team oversees the MCH grantees, collaborations and partnerships as well as on evidence based strategies to improve MCH outcomes with recognition of all socio-economic factors that impact health at the community level.

Bob Bowman has served five years as Director of Genomics and Newborn Screening Program at ISDH. As Director, he oversees the Newborn Screening Program, the Early Hearing Detection and Intervention (EHDI) program, and Genomics program, including the Indiana Birth Defects and Problems Registry. Previously, Mr. Bowman served as Genetic Specialist for ISDH, where he had direct oversight of the Birth Defects and Problems Registry. Prior to joining ISDH, Bob received a Master's degree in Genetic Counseling from Indiana University, as well as two prior Master's degrees in Secondary Education and Developmental Biology and Genetics from West Virginia University.

Andrea L. Wilkes joined ISDH as a Public Health Administrator in MCH in November 2000. She serves as the Project Manager for the Early Childhood Comprehensive Systems grant (Indiana's Sunny Start: Healthy Bodies, Healthy Minds initiative) and supervises two professional staff in the program area of child health. She earned two bachelor degrees (English and Psychology) from Miami University in Oxford, OH, Prior to her employment with MCH, Ms. Wilkes joined State service with the Disability Determination Bureau of FSSA. She served as a manager of a disability claims adjudication unit for many years, during which time she was assigned as a consultant to the Office of the Commissioner at Social Security Administration Headquarters in Baltimore, MD.

Larry S. Nelson, Public Health Administrator, serves as a Team Leader and the Training Manager for MCH. Larry has a B.S. from Indiana State University with a concentration in Public Administration and Political Science. Larry has served in the position of Prenatal Substance Use Prevention Director for one year, CSHCS Team Leader for ten years and in his current position as MCH Team Leader for five years.

Vanessa Daniels, MPA, MRC, CRC, became the Business and Grants Management section's manager and supervises the Assistant Grants Manager and the MCH Administrative Support Section. Vanessa has a Bachelors of Science in Business Management and Human Resource Management. She also has two Masters Degrees: one an MPA in Public Affairs and Nonprofit Management as well as a MRC in Counseling and is a licensed Rehabilitation Counselor with 12 years of grants management and grant writing experience. Additional staff that are a part of the Business Management Section includes an Assistant Grants Manager with over 15 years experience in State government, an Administrative Assistant, three support staff, and one contract support staff.

The MCH Data Analysis Section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies such as all of the MCH projects and clinics in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section is headed by Joel Conner, a Public Health Administrator with a BS in Education and over twenty years of data analysis experience. Joe Haddix, MPH, serves as epidemiologist for Title V programs.

Hope Munn is a social worker who began her career in 2000 after completing her undergraduate studies and earning a Bachelor of Social Work degree from Indiana University. In 2006, she earned a Master of Social Work degree also from Indiana University. Ms. Munn has served in numerous social service settings with various populations including families with low income; veterans with mental illness; persons who are homeless; individuals/families of domestic violence; and children with mental illness and/or behavioral challenges. Ms. Munn's experience as a social worker includes eligibility determination for public assistance programs, provision of in-home counseling to at-risk children/families, and facilitation of care coordination of mental health services. Ms. Munn was recently hired as supervisor of the IFHL and brings social work expertise to the MCH leadership team.

The CSHCS Division's management team includes the CSHCS Director, CSHCS Eligibility Manager, CSHCS Claims Manager, CSHCS Prior Authorization Manager, CSHCS Provider Relations Manager and the CSHCS System Manager. In 2007, the CSHCS division added the Integrated Community Services Program and a manager were hired to lead that program. In 2009, the Integrated Community Services Program was awarded a HRSA/MCHB grant to work on systems of care improvement for children and youth with special healthcare needs and their families. The project employs five contract staff to facilitate the work of the project. Two of the team members are parents with children having special health care needs.

Role of Parents of Special Needs Children

Parents of children with special health care needs are members of MCH and CSHCS as paid staff and serve in the important role of providing support and leadership to families navigating the complexities of determining diagnosis, treatment, and follow up necessary for their children. Staff support the EHDI Program Director and the Guide By Your Side program. The EHDI program has employed parents via contract agencies since June 2007. Currently, the EHDI program includes three parents as staff members, all of whom are contracted through Indiana Hands & Voices, a parent support organization. One parent works as the Parent Program Coordinator. They oversee the two EHDI parent consultants, is the primary contact for families of children diagnosed with hearing loss through EHDI, and is the coordinator of the Guide By Your Side (GBYS) Program. GBYS is a parent-to-parent mentor program that is offered jointly through EHDI and Indiana Hands & Voices. The primary role of the two EHDI Parent Consultant is to conduct follow-up activities (phone calls and letter generation) to families of the nearly 2,000 children who are referred to EHDI annually after receiving a did not pass newborn hearing screening result. One parent consultant is bilingual (Spanish). The other parent consultant has a child who has been diagnosed in the past year and so is highly familiar with negotiating the current process of hearing loss identification and early intervention.

Additionally two other parent consultants serve on the IN CISS project and provide parent perspective to the Project in developing/selecting educational materials and information and developing policies and procedures. They assist in IN CISS Advisory Committee and Leaning Collaborative and training meeting preparation, staffing of the IN CISS Advisory Committees, reviewing Learning Collaborative/Quality Improvement Tool Kit materials, and providing parent perspective training and technical assistance to the quality improvement medical home team practices participating in the Learning Collaborative. Parent consultants assist the project and the practices in the identification, recruitment, and training of parents for participation on practice teams and IN CISS Advisory committee representation. They assist with the development of the agendas for the conference calls and conferences, scheduling practice visits (currently nine pediatric/family practices), and helping collect data.

The About Special Kids (ASK) contract supports parent involvement by using trained and experienced Parent Liaisons to provide peer support, information and referral, and education and training for families of CSHCN. Activities include sending a monthly e-newsletter, developing and sending out educational materials, operating an information "hotline" and a system of follow-up contact with families, conducting training sessions, and assessing the ongoing and changing

needs of families with special health needs. ASK, utilizes family input to develop strategies to address issues such as childcare, community resources, early intervention, and health care financing.

E. State Agency Coordination

Organizational Relationships

Title V staff excel in the area of collaboration. In many cases MCH and CSHCS provide leadership in coordinating efforts among the many public and private organizations concerned with the Title V populations.

Public Health -- The local health departments operate independently in the State of Indiana. However, the ISDH Local Health Department's Outreach Office hosts a monthly conference call and webcast. Agenda topics are gathered from the various commissions at ISDH. The MCH Division uses this opportunity to broadcast updates to the 92 counties throughout the State. In addition, the Outreach Office has established an online communication tool which allows not only a sharing of information but also coordination of events.

Mental Health & Alcohol and Substance Abuse -- The Division of Mental Health and Addiction (DMHA) provides input to the Social, Emotional & Training Committee of the Early Childhood Comprehensive Systems (ECCS) initiative. For example, DMHA recently awarded $50,000 to MCH to further the goal of developing a certification program for infant and toddler mental health professionals. DMHA also provides supplemental funding support for seven PSUPP sites and collaborate on the Access to Recovery (ATR) program for pregnant women with substance abuse problems. A representative from DMHA participates in the Indiana Coalition to Improve Adolescent Health (ICIAH).

Education -- DOE is a core partner in the Early Childhood Comprehensive Systems initiative and Indiana Community Integrated Systems of Service (IN CISS) Project Advisory Committee. DOE is also instrumental in the administration of the Youth Risk Behavior Survey (YRBS). DOE participates on the EHDI Advisory Committee and is an integral partner with CSHCS on early and late transition committees. DOE also assists in training and curricula on HIV and sexuality issues for adolescents (This includes a recent MCH-DOE partnership on a recent federal grant application for a new statewide teen pregnancy prevention program).

Vocational Rehabilitation/Disability Determination/Rehabilitation Services -- MCH and CSHCS work closely with several divisions in FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps, which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps, Indiana's Early Intervention Program, also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Medicaid, SCHIP/Social Security Administration -- OMPP, under FSSA, is a key collaborator in the establishment of payment policies and procedures for CSHCS and the development of the Family Information & Resource Directory, Sunny Start Financial Fact sheets, and the Sunny Start Developmental Calendar in both English and Spanish. OMPP has also been instrumental in several prenatal initiatives including PNCC and FCC education for Medicaid Managed Care Organizations; creation of the physician's Notification of Pregnancy forms for prenatal first visits; development of a new Prenatal Risking tool sensitive to psychosocial and nutrition issues; and participation in Quality Improvement Initiatives and setting of performance measures such as Neonatal Quality Outcomes and prenatal smoking cessation. OMPP is also assisting in the assessment and review of child health with the development of the ‘State of the Hoosier Child"

report. Working with MCH, IPN, Indiana March of Dimes (MOD), and Indiana Primary Health Care Association, OMPP restructured presumptive eligibility for pregnant women in July 2009.

Corrections -- MCH partners with the Department of Corrections (DOC) to provide to funding for "Wee Ones Nursery" (WON). WON is located at the Indiana Women's Prison and provides care for children from birth up to 18 months. The goal of the program is to reduce infant placement into foster care and allow an opportunity for bonding and attachment between mothers and their newborns.. DOC also offers the Mother and Child Safe Care and Development program and works with Craine House, a step down program for early release of mothers.

Federally Qualified Health Centers -- In 2010, ISDH is funding 46 community health centers (CHCs) that have over 85 locations throughout Indiana. The Office of Primary Care (OPC) provides CHC support with funds from the Master Tobacco Settlement as authorized by the Indiana General Assembly in March 2009. Nineteen community health centers are designated FQHCs. The CHCs are located in 43 of 92 counties. Ten counties have more than one CHC. There are an additional 58 Rural Health Centers in Indiana.

The OPC and MCH share information on statewide needs and how funding is distributed. MCH funds four CHCs for prenatal care coordination. Many CHCs were originally funded as MCH clinics, but they have now developed into comprehensive primary care centers. MCH staff share health information and educational materials with Indiana CHCs through the OPC mailing lists. In addition to sharing of information via staff, activities are also coordinated between MCH, CHCs, and local health departments using a web-based tool.

Primary Care Associations -- The Indiana Primary Health Care Association (IPHCA), advocates for quality health care for all persons residing in Indiana and supports the development of community-oriented primary care initiatives. IPHCA partners regularly with MCH by providing staffing on many MCH committees and councils.

MCH Medical Director works with IPHCA to increase primary care physicians in Indiana through the J-1 Visa Waiver program. IPHCA participates in the development of the Oral Health Coalition.

Tertiary Care Facilities -- The CSHCS program funds an enrollment office at Riley Children's Hospital in Indianapolis, Indiana. CSHCS also trains other hospitals on how to enroll children needing services. Title V also funds five hospital-based genetics clinics throughout the State. These clinics provide both local and outreach services, expanding the effective number of clinics to 13. Services provided at these clinics cover both prenatal genetic counseling as well as pediatric consultation. Prenatal counseling includes the management of high risk pregnancies and provides services such as ultrasound, amniocentesis, and first trimester screening. Several specialty clinics address issues including bone dysplasia, neurogenetics, fetal alcohol syndrome and Marfan syndrome.

Representatives from the Indiana Hospital Association and representatives from several hospitals have been particularly active on committees and coalitions to improve perinatal outcomes. Hospital medical staff serve on our Prematurity Prevention Initiative Committee. Several hospital staff have committed to assisting in the development of obstetric and newborn levels of care in FY 2011.

Technical Resources and Health Professional Educational Programs and Universities -- IUSOM provides research and evaluation, particularly on adolescent health and behavior, for committees and grantees. Indiana University also participates in the Leadership Education in Neurodevelopmental and Related Disorders (LEND) program. Purdue University provides technical assistance and maintains websites, especially those related to adolescent health. The National Association for Social Workers provides professional certification of prenatal care coordinators. IPN provides professional education pertaining to prenatal care. Organizations

such as the Indiana Society for Public Health Education (InSOPHE) provide public health seminars and forums to allow sharing of information and relationship-building.

MCH Medical Director facilitates a month-long elective in Public Health/Preventative Medicine for eight to ten senior medical students per year. In addition, students pursuing a Master's degree in public health frequently perform their internship and project at MCH.

Coordination of Title V Programs with Other Federal Programs and Providers

MCH collaborates with numerous providers and many federal programs to ensure that services are available and accessible to members of the MCH population. In addition, MCH partners with other organizations in the sharing of data and the funding of services. Some examples of collaborative efforts follow.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) -- HealthWatch/EPSDT is the coordinated program established by OMPP to provide periodic screening for children under the age of 19. Information concerning Title V and Medicaid providers can be obtained using the toll-free number to the IFHL.

Womens, Infants and Childrens (WIC) -- WIC has numerous partnerships with Divisions within the HHS Commission as well as within ISDH. The IFHL, funded and administered by MCH, provides referrals not only to WIC but also other appropriate agencies. Twenty-one of the WIC clinics house the MCH Free pregnancy testing program. WIC also partners with the immunization program that promotes immunization across the State. The Indiana Lead Safe and Healthy Homes program (ILHHP) collaborate with WIC in the use of the I-LEAD web application to produce consistent and effective risk assessments and environmental information.

Disability -- Both MCH and CSHCS work closely with several divisions in the FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Family Planning Programs -- The Indiana Family Planning Partnership is a partnership among the Indiana Family Health Council (IFHC), ISDH, the Indiana Department of Child Services (IDCS) and FSSA. These agencies have agreed that the coordinated funding of family planning services in Indiana will increase access to services ensure quality of services, and minimize administrative overhead. All funds have been granted to the IFHC, Indiana's Title X agency. IFHC contracts with local agencies in locations with the highest risk populations to provide comprehensive reproductive health and family planning services to the citizens of Indiana. The goal of the coordinated funding is to use the public family planning funds as efficiently and effectively as possible to target the women most in need, to provide complete services to all low income women, to maximize Indiana competitive position family planning funding regionally, and to minimize the amount of paperwork for the providers.

OMPP has had a Family Planning Waiver request at the federal level for at least two years. Under the Health Care Reform legislation, states now have the option to expand Medicaid eligibility for family planning services without obtaining a federal waiver. The IPN has shared this new information with representatives from the OMPP, ISDH, and others involved in efforts to secure the waiver's approval. Whether changes can be made under current fiscal constraints is unknown at this time.

Identification of Pregnant Women and Infants Eligible for Title XIX
In 2009, Indiana initiated a presumptive eligibility program for pregnant women who might qualify

for Medicaid. The need for the program resulted from a flawed enrollment system that caused long delays in eligibility determination. To participate in the Presumptive Eligibility Program, Indiana requires that health care providers (clinics, OB/GYN, pediatricians, etc) enroll with Indiana Health Coverage Programs (IHCP). These providers must collect basis income information on clients and submit it to Medicaid. They may then provide services which will be reimbursed by Medicaid even if the woman does not turn out to be eligible for Medicaid. The pregnant woman has the responsibility to submit a full application to Medicaid within a certain time period so that she will be enrolled with a Hoosier Healthwise managed care program. MCH assists this mission with its Free Pregnancy Test program. The program focuses on outreach to sexually active women of child-bearing age to improve access to primary, prenatal, and family planning care to impact the State's high infant mortality rate.

State Disabilities Determination and Vocational Rehabilitation -- CSHCS works through DDRS in the Indiana FSSA to determine services and rehabilitation for children with special health care needs. First Steps, Indiana's early intervention program, coordinates services for/with CSHCS. Healthy Families Indiana, another early intervention program, identifies, at the time of birth, those families that are at risk of child abuse. CSHCS
provides financial support for the training efforts involved in this statewide home visiting program. CSHCS coordinates with developmental disabilities programs primarily through interactions with the First Steps Program and with the UNHS/EHDI follow-up efforts. Coordination with vocational rehabilitation programs is conducted primarily through the database of providers maintained by the IFHL. IFHL provides appropriate referral contacts to statewide vocational rehabilitation offices and agencies.

Family Leadership and Support Programs -- MCH and CHCS partner with a wide variety of family leadership and support organizations. Support of the national First Candle infant crib distribution program in the prevention of infant deaths is one such example of collaboration. Other collaboration efforts include the ASK program that provides resources, referrals and a parent-to parent exchange mechanism for families of children with special health care needs. Collaboration with State and local breastfeeding coalitions provides a means of increasing the rates of breastfeeding in Indiana. ICIAH is an organization dedicated to the improvement of adolescent health. The mission of ICIAH is to empower adolescents and emerging adults (ages 10-24) to choose lifestyle behaviors that will improve their quality of life and address their unique health needs.

Over the last four years, CSHCS and EHDI have developed significant partnerships with Family Leadership and Support Programs. Involvement and employment of parents is discussed in Section C, Other Capacity. The Title V program is now working closely and contracting with ASK, which is a "Parent to Parent" organization that works throughout the State of Indiana to answer questions and provide support, information and resources to help families and professionals understand the various systems that are encountered related to special needs. The CSHCS Director serves on the Governor's Council for People with Disabilities which is an independent State agency that promotes public policy leading to the independence, productivity and inclusion of people with disabilities in all aspects of society. The CSHCS program also interacts with IN*SOURCE, the Indiana Resource Center for Families with Special Needs, which provides parents, families, and service providers in Indiana with the information and training necessary to help assure effective educational programs and appropriate services for children and young adults with disabilities. Family members and professionals from the Indiana Autism Society participate in the IN CISS Advisory Committee. CSHCS and EHDI also work with Indiana Family to Family (INF2F), an organization devoted to linking families to people, information, and resources within their own communities. INF2F brings together parents of young children with disabilities, developmental delays or special health care needs so they can share their knowledge, concerns, and experiences with each other.

F. Health Systems Capacity Indicators

Introduction

The MCH Director oversaw the development of the Health Systems Capacity Indicators for the 2011 Application. The Director's interest stems from (1) our close working relationship with Medicaid because over 50% of our pregnant women are Medicaid recipients, (2) the continuing decrease in black women who receive adequate prenatal care, (3) the stagnant or declining health status indicators and performance measures, (4) worsening disparities, and (5) the need for innovative interventions that promote a life course health systems perspective.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	28.9	25.0	22.9	25.8	22.9
Numerator	1243	1076	1002	1141	
Denominator	430439	431089	437494	443089	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Projection made based on prior years' data.

2009 data not yet available. Source will be ISDH Asthma (Chronic Disease Program).

Notes - 2008

Source of data: ISDH Asthma (Chronic Disease Program)

Notes - 2007

Source of data: ISDH Asthma (Chronic Disease Program)

Narrative:

The data source for HSC Indicator #1 is the ISDH Asthma Program, from their analysis of hospital records. The ISDH Asthma Program is housed in the Chronic Disease Division of the Health and Human Services Commission. Starting in 2002, state law required all hospitals to report individual level hospitalization data to the ISDH. For this reason, data from years before 2002 cannot be compared to the years 2002 onward. The Asthma Program uses 2002 as the baseline year for comparing hospitalization data.

The rate of children hospitalized for asthma remains highest among children under 5 years of age, and drops significantly for children ages 5 through 7. Asthma hospitalization rates for children under 5 years of age decreased each year from 38.7 per 10,000 in 2003 to 22.9 per 10,000 in 2007. However, in 2008, the rate increased to 25.75 per 10,000 children less than five years of age. Among young children, asthma hospitalization rates for males were higher than for females. The hospitalization rate for males under 5 years of age due to Asthma in Indiana in 2005 was 33.0 per 10,000 versus 17.0 for females.

The Indiana Joint Asthma Coalition was formed in early 2003. The Statewide Asthma Strategic

Plan was finalized in December 2004. Since then coalition members, communities and the State Asthma Program staff at ISDH have been working on educating the public; continuing education for providers; improving care of children with asthma in child care and school settings; and monitoring available asthma data in Indiana. A priority objective has been to decrease asthma hospitalizations and there appears to have been some success in that area.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	61.4	83.4	83.2	78.6	79.2
Numerator	52964	44186	43067	41019	40798
Denominator	86298	52965	51784	52184	51545
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data provided By OMPP using their new data system.

This system has been revised and is providing comprehensive data as of CY2008. Data calculated for 2006 and 2007 using 2008 data supplied has necessitated a change in the 2006 data and given projections for 2007.

Source of data: OMPP

Notes - 2008
Data provided By OMPP using their new data system.

This system has been revised and is providing comprehensive data as of CY2008. Data calculated for 2006 and 2007 using 2008 data supplied has necessitated a change in the 2006 data and given projections for 2007.

Source of data: OMPP

Notes - 2007
Data provided By OMPP using their new data system.

This system has been revised and is providing comprehensive data as of CY2008. Data calculated for 2006 and 2007 using 2008 data supplied has necessitated a change in the 2006 data and given projections for 2007.

Source of data: OMPP

Narrative:
ISDH receives Medicaid data from the Office of Medicaid Policy and Planning (OMPP), a division of Family Social Services Administration (FSSA). In 2009, 79.2% of Medicaid enrollees under the

age of one received at least one initial periodic screen. The 2009 results are consistent with 2008 results of 79%.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	12.1	91.7	91.7	47.1	47.1
Numerator	186	88	88	48	40
Denominator	1531	96	96	102	85
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data provided By OMPP using their new data system.

This system has been revised and is providing comprehensive data as of CY2008. Data calculated for 2006 and 2007 using 2008 data supplied has necessitated a change in the 2006 data and given projections for 2007.

OMPP and SCHIP have just been combined. There will be one report for both in future. The final Mediciad report has increased figures and the final SCHIP report has decreased figures.

Source of data: OMPP

Notes - 2008
Data provided By OMPP using their new data system.

This system has been revised and is providing comprehensive data as of CY2008. Data calculated for 2006 and 2007 using 2008 data supplied has necessitated a change in the 2006 data and given projections for 2007.

OMPP and SCHIP have just been combined. There will be one report for both in future. The final Mediciad report has increased figures and the final SCHIP report has decreased figures.

Source of data: OMPP

Notes - 2007
Data provided By OMPP using their new data system.

This system has been revised and is providing comprehensive data as of CY2008. Data calculated for 2006 and 2007 using 2008 data supplied has necessitated a change in the 2006 data and given projections for 2007.

Source of data: OMPP

Narrative:
The OMPP division of FSSA also reported that in 2009, 47% of State Children's Health Insurance Program (SCHIP) enrollees under the age of one received at least one initial periodic screen. This rate is comparable to the 2008 rate of 47%. The main reason for the difference between Medicaid's and SCHIP's results is that there are very few individuals under the age of one year enrolled in the SCHIP program. In 2008 only 102 individuals less than one year of age were enrolled in SCHIP, and in 2009 only 85 individuals less than one year of age were enrolled in SCHIP.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	71.1	57.3	70.3	69.8	70.5
Numerator	61767	50431	62945		
Denominator	86887	87936	89538		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data not available. Projection made based on prior years' data.

Source of data will be ISDH ERC.

Notes - 2008
Source of data will be ISDH ERC.

Notes - 2007
Source of Data: ISDH ERC and Epidemiologist.

Narrative:
The data source for HSC Indicator #4 is the National Center for Health Statistics, final natality data (retrieved March 2009 from www.marchofdimes.com/peristats).

Between 2003 and 2005, 73.4% of all women in Indiana had adequate or adequate plus prenatal visits according to the Kotelchuck Index. In 2007, the percentage decreased to 70.3%, and provisional 2008 data shows even a further decrease to 69.8% of Indiana residents having adequate prenatal care. The rate and the denominator for this figure are provided annually by the ISDH Epidemiology Resource Center. The the numerator is calculated after receipt of the rate and denominator.

Use of the revised 2007 Birth Certificate has resulted in a decrease in the rate of early entry into prenatal care which also impacts this indicator. The MCH Epidemiologist is also analyzing prenatal care by race, ethnicity, and county-specific data. The Medicaid enrollment problems that have occurred in Indiana since 2007 have likely had a negative influence on access to adequate prenatal care. The expectation is that the new enrollment system, coupled with the

adoption of Presumptive Eligibility in July 2009, should improve this HSC Indicator.

The Maternal and Child Health Division of ISDH and its partner, the Indiana Perinatal Network (IPN), took a leadership role in promoting the policy of Presumptive Eligibility (PE), which allows pregnant women to enter prenatal care under the assumption they will be Medicaid eligible. IPN continues to educate providers throughout the State about PE, and MCH's Indiana Family Helpline provides PE information to women and families.

The Office of Medicaid Policy and Planning has made the percent of women entering prenatal care in the first trimester a State Medicaid performance measure for State Medicaid Managed Care Organizations (MCOs).

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	89.7	89.1	89.9	95.3	95.3
Numerator	442210	587109	602779	647994	
Denominator	492835	659227	670468	679769	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data is not available yet, Projections made depending on the previous years.

Data from OMPP received for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Notes - 2008
Data from OMPP received for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Notes - 2007
Data from OMPP received for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Narrative:
The data source for this HSC Indicator is the Office of Medicaid Policy and Planning (OMPP), a division of Family Social Services Administration (FSSA). According to OMPP, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program is 92.4% in 2009. This percentage is consistent with the small increases annually since 2004. However, differences were found within specific populations. Among Medicaid-eligible children,

77% of white non-Hispanic children had primary care office visits, compared to only 62% of black non-Hispanic, and 67% of Hispanic children.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	47.7	51.7	55.3	58.2	60.3
Numerator	73219	68790	75577	79887	88073
Denominator	153452	133058	136558	137177	146107
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source of data: OMPP (Medicaid)

Notes - 2008
Data from OMPP received for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Notes - 2007
Data from OMPP received for 2006, 2007, and 2008. 2006 should be treated as baseline data.

Source of data: OMPP (Medicaid)

Narrative:
According to OMPP, the percent of EPSDT eligible children aged 6-9 years who have received any dental services during the year is 60.3% in 2009. This percentage is consistent with the trend of small increases since 2004.

Dental visits increased among all age groups and all race and ethnicity groups between 2008 and 2009. This is due to an increase in Medicaid reimbursement rates for dental services, which resulted in an increase in the number of dentists who accept Medicaid patients.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.0	2	2	5.7	6.3
Numerator	401			1126	1256
Denominator	19823			19823	19823
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Projected figure used. With numbers so low, fluctuation is possible, but unlikely to have a large impact in the indicators now that accurate data (from 2005) has eliminated the duplicates from 2004 and earlier. Source of denominator will be SSA/SSI web page when updated by the Feds to include 2008 data. Source of numerator will be ISDH CSHCS program at the same time.

Notes - 2008
Projected figure used. With numbers so low, fluctuation is possible, but unlikely to have a large impact in the indicators now that accurate data (from 2005) has eliminated the duplicates from 2004 and earlier. Source of denominator will be SSA/SSI web page when updated by the Feds to include 2008 data. Source of numerator will be ISDH CSHCS program at the same time.

Notes - 2007
With numbers so low, fluctuation is possible, but unlikely to have a large impact in the indicators now that accurate data (from 2005) has eliminated the duplicates from 2004 and earlier. Source of data: ISDH CSHCS, Federal SSA/SSI data.

Narrative:
The data source for this capacity indicator is the Children with Special Health Care Needs report. Updated data is not yet available from SSI. Of note, the CSHCN report available at this time (2009 data) includes children through age 18, not age 16. The report for next year will be available for 0-16 year olds.

Currently, the 2009 percentage of State SSI beneficiaries less than 18 years old receiving rehabilitation services from the CSHCN program is 6.33%, which is an increase from 5.68% in 2008.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	other	8.1	6.3	6.9

Notes - 2011
Source of data will be ISDH - ERC and OMPP (Medicaid)

Narrative:
Indiana's goal is to eliminate disparities between Medicaid and non-Medicaid populations for pregnancy health outcomes. Indiana State Department of Health is partnering with OMPP to

improve the quality of services for pregnant women and infants. Our combined goals are to improve several perinatal indicators, including birth weight, NICU admissions, complications, preterm births, infant mortality and prenatal care. Presumptive eligibility started in July of 2009 to enroll pregnant women into Medicaid early in the pregnancy.

Currently in Indiana, non-Medicaid pregnant women have better birth health outcomes than their Medicaid peers. The low birth weight percentage for the Medicaid population is 8.1%, which is much higher than the 6.3% for the non-Medicaid population. The infant mortality rate for Medicaid population (7.5 per 1,000) is also higher than the non-Medicaid population, (6.5 per 1,000). The percentage of women receiving prenatal care in the first trimester on Medicaid is much lower (60.6%) than the population not on Medicaid (74.4%). The Medicaid population whose prenatal care was adequate (68.4%) is much lower than the non-Medicaid population (72.9%).

Please note that these are provisional figures provided by the Indiana State Department of Health's Epidemiology Resource Center and will be revised prior to public release.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	other	7.5	6.5	6.9

Notes - 2011
Source of data will be ISDH - ERC and OMPP (Medicaid)

Narrative:
Indiana's goal is to eliminate disparities between Medicaid and non-Medicaid populations for pregnancy health outcomes. Indiana State Department of Health is partnering with OMPP to improve the quality of services for pregnant women and infants. Our combined goals are to improve several perinatal indicators, including birth weight, NICU admissions, complications, preterm births, infant mortality and prenatal care. Presumptive eligibility started in July of 2009 to enroll pregnant women into Medicaid early in the pregnancy.

Currently in Indiana, non-Medicaid pregnant women have better birth health outcomes than their Medicaid peers. The low birth weight percentage for the Medicaid population is 8.1%, which is much higher than the 6.3% for the non-Medicaid population. The infant mortality rate for Medicaid population (7.5 per 1,000) is also higher than the non-Medicaid population, (6.5 per 1,000). The percentage of women receiving prenatal care in the first trimester on Medicaid is much lower (60.6%) than the population not on Medicaid (74.4%). The Medicaid population whose prenatal care was adequate (68.4%) is much lower than the non-Medicaid population (72.9%).

Please note that these are provisional figures provided by the Indiana State Department of Health's Epidemiology Resource Center and will be revised prior to public release.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	other	60.6	74.4	66.7

Notes - 2011
2007 data on prenatal care and smoking during pregnancy will not be comparable to earlier years because the questions asked of the mother are quite different on the revised (2003) certificate which Indiana adopted on January 1, 2007.

Source of data will be ISDH - ERC and OMPP (Medicaid)

Narrative:
Indiana's goal is to eliminate disparities between Medicaid and non-Medicaid populations for pregnancy health outcomes. Indiana State Department of Health is partnering with OMPP to improve the quality of services for pregnant women and infants. Our combined goals are to improve several perinatal indicators, including birth weight, NICU admissions, complications, preterm births, infant mortality and prenatal care. Presumptive eligibility started in July of 2009 to enroll pregnant women into Medicaid early in the pregnancy.

Currently in Indiana, non-Medicaid pregnant women have better birth health outcomes than their Medicaid peers. The low birth weight percentage for the Medicaid population is 8.1%, which is much higher than the 6.3% for the non-Medicaid population. The infant mortality rate for Medicaid population (7.5 per 1,000) is also higher than the non-Medicaid population, (6.5 per 1,000). The percentage of women receiving prenatal care in the first trimester on Medicaid is much lower (60.6%) than the population not on Medicaid (74.4%). The Medicaid population whose prenatal care was adequate (68.4%) is much lower than the non-Medicaid population (72.9%).

Please note that these are provisional figures provided by the Indiana State Department of Health's Epidemiology Resource Center and will be revised prior to public release.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	68.4	72.9	69.8

Notes - 2011
2007 data on prenatal care and smoking during pregnancy will not be comparable to earlier years because the questions asked of the mother are quite different on the revised (2003) certificate which Indiana adopted on January 1, 2007.

Source of data will be ISDH - ERC and OMPP (Medicaid)

Narrative:
Indiana's goal is to eliminate disparities between Medicaid and non-Medicaid populations for pregnancy health outcomes. Indiana State Department of Health is partnering with OMPP to improve the quality of services for pregnant women and infants. Our combined goals are to improve several perinatal indicators, including birth weight, NICU admissions, complications, preterm births, infant mortality and prenatal care. Presumptive eligibility started in July of 2009 to enroll pregnant women into Medicaid early in the pregnancy.

Currently in Indiana, non-Medicaid pregnant women have better birth health outcomes than their Medicaid peers. The low birth weight percentage for the Medicaid population is 8.1%, which is much higher than the 6.3% for the non-Medicaid population. The infant mortality rate for Medicaid population (7.5 per 1,000) is also higher than the non-Medicaid population, (6.5 per 1,000). The percentage of women receiving prenatal care in the first trimester on Medicaid is much lower (60.6%) than the population not on Medicaid (74.4%). The Medicaid population whose prenatal care was adequate (68.4%) is much lower than the non-Medicaid population (72.9%).

Please note that these are provisional figures provided by the Indiana State Department of Health's Epidemiology Resource Center and will be revised prior to public release.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	250

Narrative:
The percent of poverty level for children's eligibility in the State's Medicaid program is 250% of the federal poverty level (FLP).

Indiana's SCHIP program is part of Hoosier Healthwise, which is the State's insurance program for children, pregnant women and low-income working families. In 2008, the Indiana Family and

Social Services Administration received Federal approval to increase eligibility to children in families with incomes up to 250% of the federal poverty level. However, there is a small co-pay for infants and children in families between 150% and 250% of FPL.

Eligibility for pregnant women and low-income families under Hoosier Healthwise is 200% of the federal poverty level.

Low-income families can be eligible for Hoosier Healthwise, if there are children under the age of 18 living with their parent(s). All applicants must be residents of Indiana. Non US-citizens who meet all financial and categorical requirements may be eligible for full or limited coverage, depending on their immigration status.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	250

Narrative:
The percent of poverty level for children's eligibility in the State's Medicaid program is 250% of the federal poverty level (FLP).

Indiana's SCHIP program is part of Hoosier Healthwise, which is the State's insurance program for children, pregnant women and low-income working families. In 2008, the Indiana Family and Social Services Administration received Federal approval to increase eligibility to children in families with incomes up to 250% of the federal poverty level. However, there is a small co-pay for infants and children in families between 150% and 250% of FPL.

Eligibility for pregnant women and low-income families under Hoosier Healthwise is 200% of the federal poverty level.

Low-income families can be eligible for Hoosier Healthwise, if there are children under the age of 18 living with their parent(s). All applicants must be residents of Indiana. Non US-citizens who meet all financial and categorical requirements may be eligible for full or limited coverage, depending on their immigration status.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Narrative:
The percent of poverty level for children's eligibility in the State's Medicaid program is 250% of the federal poverty level (FLP).

Indiana's SCHIP program is part of Hoosier Healthwise, which is the State's insurance program for children, pregnant women and low-income working families. In 2008, the Indiana Family and Social Services Administration received Federal approval to increase eligibility to children in families with incomes up to 250% of the federal poverty level. However, there is a small co-pay for infants and children in families between 150% and 250% of FPL.

Eligibility for pregnant women and low-income families under Hoosier Healthwise is 200% of the federal poverty level.

Low-income families can be eligible for Hoosier Healthwise, if there are children under the age of 18 living with their parent(s). All applicants must be residents of Indiana. Non US-citizens who meet all financial and categorical requirements may be eligible for full or limited coverage, depending on their immigration status.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes

REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2011

Narrative:
The Maternal and Child Health program and Title V agency continues to have increased access to relevant information and data through data linkage and integration, and increased collaboration with internal ISDH divisions and with other State agencies. ISDH data is housed in the Integrated Data System (IDS), an operational database for integration and storage of person-centric and event data. The Electronic Birth Certificate (EBC) and Electronic Death Certificate (EDC) are now providing data to the Integrated Data System (IDS). Applications that act as source data for the IDS include Vital Records, the Indiana Birth Defects and Problems Registry (IBDPR), Newborn Hearing and Newborn Screening, and the new Notice of Pregnancy data from the Office of Medicaid Policy and Planning. Through use of the IDS, person-centric data is more accessible and complete due to integration of multiple data sources. MCH applications are able to benefit directly from this real-time comprehensive or "integrated view" from the IDS database.

The ISDH administered the 2009 Youth Risk Behavior Survey under an agreement with the Department of Education, and obtained weighted data. A new Memorandum of Understanding is in place with the Office of Medicaid Policy and Planning to provide ISDH/MCH needed data. The WIC Program is now in the same Commission as the Maternal and Child Health program, and is sharing data.

The State Systems Development Initiative (SSDI) grant to MCH provides for staff to identify web-based solutions for data integration and linkage and to support the IDS. In 2011, MCH will seek funding to reactivate a PRAMS or PRAMS-like survey. Additionally, MCH will be working to develop a more robust data manual to support ongoing needs assessment.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
Indiana high-school students are marginally more likely (23.5%) than their national counterparts (19.5%) to smoke cigarettes, according to the findings of the 2009 Indiana Youth Risk Behavior Survey conducted by the Indiana State Department of Health. Forty-seven high schools in the state and 1,515 students in grades 9 through 12 participated in the survey, which is part of a

national study initiated by the Centers for Disease Control and Prevention to monitor student's health risks and behaviors. In 2003, enough high schools in the state responded to the survey to allow the data collected to be weighted, that is, to be generalized for all Indiana high-school students. The Indiana Youth Risk Behavior Survey has been completed for 2009 with enough completed surveys to produce a weighted sample. This allows trending for the years between 2003, 2005, 2007 and 2009.

The Indiana Youth Tobacco Survey was completed in July of 2009, covering the year 2008, for Indiana youth in grades 6-12 at more than 90 schools statewide. This survey found smoking among high school youth is at 18%, a 21% decline from 2006-2008, and 42% decline from 2000-2008. This survey is completed during the off years of the YRBS, so data is sometimes inconsistent between the two surveys. The survey included an over sample of African American and Hispanic youth. Indiana Tobacco Prevention and Cessation (ITPC) programs adapted the Youth Tobacco Survey, developed by the Centers for Disease Control and Prevention, by adding questions designed for Indiana to serve as a surveillance measure for statewide tobacco use prevalence among youth. The full Indiana Youth Tobacco Survey Report is available at www.itpc.in.gov.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to promote integration of public health and health care policy, strengthen partnerships with local health departments, and collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities. ISDH will also support locally-based responsibility for the health of the community. ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, MCH and CSHCS continue to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as State initiatives, based on the latest needs assessment. The needs assessment results focused on health system capacity indicators and health status indicators, including asthma hospital discharges, Medicaid/SCHIP screening, prenatal care adequacy, low/very low birth weight, fatal/non-fatal injuries, chlamydia rates, dental screening, and adolescent tobacco use.

The needs assessment results have dictated the focus of the State priorities listed in the following section, B. State Priorities. Program and resource allocation issues are determined using the State priorities for guidance. Utilizing the MCH pyramid, program and resource funding has been carefully allocated to cover not only the State priorities but also to cover all four of the pyramid levels.

Outcome measure data for infant mortality, black/white infant mortality disparity, neonatal mortality,
post-neonatal mortality, perinatal mortality, and the child death rate are also monitored and reported annually.

Specifically, within the pyramid level of direct medical services, Title V funds programs to provide genetics services, immunizations, dental sealants, sickle cell prophylactic medicine, lead poisoning prevention, direct medical care for pregnant women, infants, children, adolescents, family planning, STD screens, free pregnancy screens, as well as specialty medical services and primary care for CSHCN. Funded Enabling Services programs provide genetics services education, prenatal and family care coordination, newborn screening and referral, sickle cell management, prenatal substance use prevention program (PSUPP), and coordination with Medicaid and WIC in addition to many other programs.

Population-based services that are provided or funded by Title V include the Indiana Family Helpline (IFHL), the Early Childhood Comprehensive Systems (ECCS) program, the Indiana Joint Asthma Coalition (InJAC), the adolescent pregnancy prevention initiative, sudden infant death prevention, dental fluoridation efforts, and fetal infant mortality review. ISDH Infrastructure Building Services include efforts such as the Indiana Perinatal Network; the MCH, NBS and PSUPP data systems; the integration of data systems to facilitate the Indiana Birth Defects and Problems Registry (IBDPR), the Genomics in Public Health and Newborn Screening education efforts and other data analysis efforts for planning and reporting; policy and standards development; planning, evaluation, and monitoring; and quality assurance to MCH and CSHCS grantees.

Progress toward the achievement of our national and State performance goals is reported in Sections C and D following. MCH and CSHCS continue to build on previous years successes.

This year's annual report reflects that for 2009, MCH and CSHCS continue to make progress on eight of the thirteen national performance measures that are not reported through the CSHCN survey. Progress was made on the five performance measures that are reported through the CSHCN survey.

MCH and CSHCS are proposing a new set of State negotiated performance measures (SPM) based on the results of the needs assessment. Two of the new SPM's are identical to the previous SPM's and one has been modified. There are seven entirely new proposed SPM's and some of the previous SPM's are being discontinued. These are enumerated in Sections B and D.

B. State Priorities

Indiana comprehensively evaluated quantitative and qualitative information to develop the State's priority healthcare needs. Indiana allocated $4,982,945 for FY 2009 in grants to community-based organizations. In the coming year, Title V staff will re-evaluate the distribution of money based on the new state priorities.

For pregnant women, priority healthcare needs include decreasing smoking during pregnancy, with emphasis on the Medicaid population; increasing the number of black women having adequate prenatal care; decreasing the proportion of births occurring within 18 months of a previous pregnancy to the same mother; and increasing the number of women who initiate exclusive breastfeeding. These priorities are related to State Performance Measures (SPM) 2, 3, 4, 6, and 7, along with National Performance Measures (NPM) 11, 15 and 18. Indiana's capacity to work on these priorities include collaboration with partners at Medicaid, Indiana Tobacco Prevention and Cessation, new initiative development for minorities, educational programs for breastfeeding mothers, and further program expansion within the State Department of Health.

Smoking during pregnancy increases the risk for both a preterm delivery as well as a low birth weight baby. Although the smoking during pregnancy rate has declined in general in Indiana, the rate is still very high for certain populations or locales. Activities to address this issue include providing training and materials to prenatal Medicaid providers; assessing/comparing counties with highest and lowest smoking rates to determine successful anti-smoking strategies; and working with Indiana Tobacco Prevention and Cessation (ITPC)/Indiana Preventing Smoking in Pregnancy Initiative to explore successful cultural and literacy appropriate educational messages targeted to low income women.

During the period from 2002 to 2006, the percentage of women, overall, receiving prenatal care within the first trimester declined from 80.5% to 77.6%. The black percentage decreased from 68.6% to 65.6% over this time period. To address the low level of entry into prenatal care for black women the new focus will target counties having a lower percentage of black women entering prenatal care in the first trimester. Initiatives will include free pregnancy tests, development of a Premature Birth Initiative especially for African American women, and collaboration with the National Fatherhood Initiative on train the trainer workshops.

Short interval pregnancies are an important issue because such pregnancies increase the risk for adverse outcomes, such as low/very low birth weight babies; premature births and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to reduce opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average

but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions; initiation of a recognition program acknowledging Baby Friendly Hospitals; and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers,

Two problems concerning infants require a special focus: prematurity rates and accidental suffocation under one year of age. Although prematurity birth rates are at about the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Executive Group driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal. These priorities are related to State Performance Measures (SPM) 1 and 7. Indiana's capacity to work on these priorities include collaboration with the First Candle Project and Indiana Perinatal Network. Indiana has started a premature birth coalition with public and private agencies that increases the State's capacity for these priorities.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will center around communication of safe sleep practices/updates to nurse managers/nursing staff and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network, and local community organizations in the four largest counties to conduct training and educational sessions.

Concerns involving children and adolescents center around lead poisoning, STDs, obesity, and social-emotional heath of very young children. These priorities are related to State Performance Measures (SPM) 5, 8, 9, and 10, along with National Performance Measures (NPM) 7, 14 and 16. Indiana is increasing the capacity to improve these priorities. Indiana will continue to work with Medicaid, and the Lead and Immunization Programs to improve children's health. The State is also increasing capacity by funding new positions that focus on youth risks, which include STD's, physical activity, and weight and nutrition. Indiana will increase capacity over the next 5 years to improve social-emotional health for children.

Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and to work with the Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated.

Reduction in the number of sexually transmitted diseases (STDs) is another state objective. Strategies to reduce the STD numbers include providing education and materials to providers treating adolescents, conducting a needs assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Indiana Family Health Council to increase screening for sexually transmitted infections.

Obesity in high school age children is also a state concern. Recent data indicate that 13.8% of youth to have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks and increased physical activity.

Addressing issues pertaining to the social-emotional health of children under the age of 5 is the final initiative. Foremost among these issues is the lack of qualified service providers to treat children is this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refuges/immigrants, and children of

deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99.2	100	100	100	98
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	111	126	132	160	176
Denominator	111	126	132	160	176
Data Source				ISDH - NBS	ISDH - NBS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Based on 4 year Average

Notes - 2008
Beginning next year we will be reporting this measure with a slightly different interpretation than in the past. Rather than treating referrals as appropriate follow-up services received, we will be tracking percentage who receive services from those referrals. Thus the figure, while high, will no longer be 100% for this measure.

Objectives have been lowered to 98% in anticipation of the lower outcome expected. 2009 will be treated as baseline data.

Source of data: ISDH NBS Program

Notes - 2007
Provisional based on calculations now used (see 2006 note for details).

a. Last Year's Accomplishments
FY 2009 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

100% of newborns whose screens were invalid, abnormal, or positive received appropriate & timely follow-up services.

All infants with confirmed positive results were referred to the Genetics, Endocrinology, and/or Metabolic Clinics at Indiana University Medical Center (IUMC); Sickle Cell clinics; First Steps; and the CSHCS programs.

Newborn Screening (NBS) continued to provide in-service training to Public Health Nurses, midwives, hospitals, and birthing centers.

NBS began to develop the Indiana NBS Tracking and Education Program (INSTEP) application in the Integrated Data System in order to provide more efficient and effective tracking and follow-up of babies who received a positive heel-stick for certain conditions.

The NBS Director participated in the Region IV Genetics Collaborative and on the NBS Subcommittee of the Indiana Genetics Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. NBS is continuing to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.			X	
2. NBS is continuing to develop the INSTEP application. This is a web-based application that will allow hospitals to quickly and accurately enter information directly into a data store and will allow Indiana NBS staff to view the entries made by hospit			X	
3. NBS is continuing to refer infants with confirmed positive results to the Genetics, Endocrinology, and/or Metabolic Clinics at Indiana University Medical Center (IUMC); Sickle Cell clinics; First Steps; and the Children's Special Health Care Services		X		
4. NBS is continuing to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. Updated presentations for hospitals and birthing facilities have been completed and will soon be available.				X
5. Changes were made to the Sickle Cell program. Children identified by newborn screen with Sickle Cell disease or another hemoglobinopathy are immediately referred to a hematologist to ensure that the child receives appropriate care.		X		
6. The NBS Director presented the INSTEP application at the Region IV Genetics Collaborative in April 2010.				X
7.				
8.				
9.				
10.				

b. Current Activities
Activities to impact this performance objective include:

Follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.

Develop the INSTEP application to allow hospitals to quickly and accurately enter information directly into a data store and Indiana NBS staff to view the entries almost instantaneously. Pilot

testing is scheduled for the spring of 2010.

Refer infants with confirmed positive results to the Genetics, Endocrinology, and/or Metabolic Clinics at IUMC; Sickle Cell clinics; First Steps; and the CSHCS programs.

Provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. Updated presentations will be available online.

Changes were made to the Sickle Cell program. These changes guarantee that children identified by newborn screen with Sickle Cell disease or another hemoglobinopathy are immediately referred to a hematologist to ensure that the child receives appropriate follow-up services and that they have a medical home with a primary care provider who is aware of appropriate resources.

The NBS Director presented on the INSTEP application at the Region IV Genetics Collaborative in April 2010.

c. Plan for the Coming Year
Activities to impact this performance objective include:

Continue to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.

Refer infants with confirmed positive results to the Genetics, Endocrinology, and/or Metabolic Clinics at IUMC; Sickle Cell clinics; First Steps; and the CSHCS programs.

Provide trainings to Public Health Nurses, hospitals, and midwives, and birthing centers. Public Health Nurses and hospital staff will have the option of completing these trainings in person or online.

Begin training all birthing facilities to submit monthly reports via the INSTEP application. This system will allow more efficient and effective tracking of newborns, thereby ensuring all children receive a valid screen and appropriate and timely follow-up.

Work with the state-contracted Metabolic Geneticist to collect follow-up information on those children diagnosed with a metabolic disorder.

The NBS Director will participate in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**89607**
Reporting Year:	**2008**

Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	89607	100.0	5	5	5	100.0
Congenital Hypothyroidism (Classical)	89607	100.0	41	41	41	100.0
Galactosemia (Classical)	89607	100.0	66	37	33	89.2
Sickle Cell Disease	89607	100.0	37	37	37	100.0
Biotinidase Deficiency	89607	100.0	4	4	4	100.0
CAH	89607	100.0	7	7	7	100.0
Cystic Fibrosis	89607	100.0	316	22	22	100.0
Maple Syrup Urine Disease	89607	100.0	1	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	89607	100.0	1	1	1	100.0
Glutaric Acidemia Type I	89607	100.0	1	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	89607	100.0	5	5	5	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	63	63	64	60	60
Annual Indicator	61.1	61.1	59.3	59.3	59.3
Numerator					
Denominator					
Data Source				SLAITS	SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	59.3	60	60	61	61

Notes - 2009
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
The Indiana Community Integrated Systems of Service Advisory Committee (IN CISS) met to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families.

The IN CISS Advisory sub-committee titled Family/Professional Partnerships subcommittee identified activities and made recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve community-based service systems around Family/Professional Partnerships. This information was used to apply for HRSA/MCHB State Implementation Grant for Improved Systems of Services for CYSHCN which was submitted March 2009. Indiana received notification of "Grant Award" on May 22, 2009 with a project start date of June 1, 2009.

The IN CISS project began June 1, 2009 and hired two parent consultants to begin work on developing parent/professional partnerships within the project's 12 Medical Home Learning Collaborative practices. The parent consultants also assisted the Children with Special Health Care Services (CSHCS) program by bringing the parent perspective to the table in work on policy, procedures and care coordination processes.

CSHCS produced and mailed a CSHCS Winter & Summer Newsletters to all participants, providers and community partners.

CSHCS continued to keep the CSHCS Program website updated to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters. Links to other resources for families were created that allowed accessibility to resource information as needed by participants and their families.

CSHCS updated and printed their English and Spanish CSHCS Program Brochures and made supplies available to all CSHCS providers, parent support agencies and other community-based systems that care for/support CYSHCN.

CSHCS continued to provide developmental calendars, transition resources (including the CSHCS Transition Manual) and health care financing options to all its age appropriate

participants.

CSHCS continued its grant funding to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing trainings, information, peer support, education and partnerships building with professionals and communities. FY 2009 activities included:
Parent to parent contact through the telephone was available to families for questions related to health care coverage, education, early intervention, community resources, training and other issues. During FY 09, a total of 3,142 new families and a total of 1,166 new professionals were served by ASK staff. In addition, 71,705 families and professionals were contacted though ASK's follow-up protocols and newsletter throughout the year. ASK had a total of 17,191 visitors to their online resource directory which contains over 2,057 available resources for CYSHCN and their families throughout the state.

ASK worked with the Integrated Community Services (ICS) Program to collect information from families and from professionals about their understanding of a medical home. Following this survey, ASK assisted the ICS program in identifying steps to take toward furthering the medical home concept in Indiana.

ASK participated with the Indiana State Department of Health (ISDH) on advisory committees to special projects, insuring that the family perspective was always present throughout the planning processes.

The CSHCS program began offering a new web portal feature to enrolled providers that will allow access to certain program information via the internet. This web portal will allow providers to check participant enrollment and claim status/history and will also enable providers to print an EOP/Remittance Advice.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Indiana Community Integrated Systems of Service Advisory Committee (IN C.I.S.S.) continues to work on improving access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Nee				X
2. The IN CISS Project began participation in a Quality Improvement exercise with the National Initiative for Children's Healthcare Quality (NICHQ) staff to promote and strengthen parent/professional partnerships in Medical Homes.				X
3. CSHCS produced and mailed a CSHCS Winter & Summer Newsletters to all participants, providers and community partners.		X		
4. CSHCS continued to keep the CSHCS Program website updated to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters. Links to other resources for families we		X		
5. CSHCS provided their updated English and Spanish CSHCS Program Brochures to all CSHCS providers, parent support agencies and other community-based systems that care/support CYSHCN.		X		
6. CSHCS continued to provide Developmental Calendars,		X		

Transition Resources- including the CSHCS Transition Manual and Health Care financing options to all its participants.				
7. ASK will continue to receive grant funding from CSHCS at a reduced amount due to budget restraints. ASK will continue its work with families and professionals served through its staff and programs. FY 2010 activities include the following: 1. P		X		
8. CSHCS participated in statewide trainings, conferences and exhibitions to promote the CSHCS program.				X
9. The Children's Special Health Care Services program continued enhancing and offering the new web portal feature to enrolled providers that will allow access to certain program information via the internet. This web portal allows providers to check pa				X
10.				

b. Current Activities

IN CISS continued monthly meetings; hired two parent consultants; sponsored two statewide medical home conferences; sponsored ongoing bi-weekly teleconferences to educate and support families; and provided ongoing trainings and conferences to support the partnerships..

The IN CISS Project began participation in a Quality Improvement exercise with the National Initiative for Children's Healthcare Quality (NICHQ) staff to promote and strengthen parent/professional partnerships in Medical Homes.

CSHCS produced and mailed CSHCS winter & summer newsletters to all participants, providers and community partners and continued to keep the CSHCS Program website updated.

CSHCS provided their updated English and Spanish CSHCS program brochures to all CSHCS providers, parent support agencies and other community-based systems that care/support CYSHCN.

CSHCS continued to provide developmental calendars, transition resources (including the CSHCS transition manual) and health care financing options to all its participants.

ASK included parent to parent contact for questions related to health care coverage, education, early intervention, community resources, training and other issues; participation with the ISDH on advisory committees; and publishing an e-newsletter with readership reaching over 18,000 during the year.

CSHCS participated in statewide trainings, conferences and exhibitions to promote the CSHCS program and offered new web portal feature to enrolled providers.

c. Plan for the Coming Year

IN CISS will improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families and continue to work on the activities outlined in the grant.

Family/Professional Partnerships subcommittee will coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve community-based

service systems around Family/Professional Partnerships.

The IN CISS project parent consultants will develop parent/professional partnerships within the project's 12 Medical Home Learning Collaborative practices and continue to assist the CSHCS program by bringing the parent perspective to the table.

The IN CISS Project will sponsor two face-to-face statewide meetings and ongoing bi-weekly teleconferences and provide ongoing trainings and conferences to support parent/professional partnerships. Information will be shared with families and financial assistance given as a support for their participation.

The IN CISS Project will participate with NICHQ staff to promote and strengthen parent/professional partnerships in medical homes.

CSHCS will produce and mail a summer and winter CSHCS newsletter; provide updated English and Spanish CSHCS program brochures; provide developmental calendars, transition resources (including the CSHCS transition manual) and health care financing options; and keep the CSHCS Program website updated.

ASK will receive grant funding from CSHCS at the previously reduced amount due to budget restraints and continue work with families and professionals served through its staff and programs. ASK will educate families and professionals about Medical Home; participate with ISDH on advisory committees to special projects, insuring that the family perspective is always present throughout the planning processes; and continue to send an e-newsletter and anticipates that readership will reach over 20,000 during the coming year.

CSHCS will participate in statewide conferences and exhibitions to promote the CSHCS program; continue enhancing and offering the new web portal feature to enrolled providers that will allow access to certain program information via the internet. This web portal allows providers to check participant enrollment and claim status/history and will also enable providers to print an EOP/Remittance Advice

The CSHCS Provider Relations Section will work with the CSHCS Care Coordination staff to address areas of opportunity to promote and enhance parent/professional partnerships.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56	56	56	55	55
Annual Indicator	55.7	55.7	54.6	54.6	54.6
Numerator					
Denominator					
Data Source				SLAITS	SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	54.6	55	55	56	57

Notes - 2009
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
The CISS Medical Home sub-committee made recommendations to coordinate for Indiana the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the goal of coordinated, ongoing, comprehensive care within a Medical Home; and worked to identify Indiana's strengths and needs around this topic and identified activities and made recommendations to coordinate the development, implementation and evaluation of the State Integrated Community Services Plan to achieve community-based service systems in the Medical Home. This information was used to apply for HRSA/MCHB State Implementation Grant for Improved Systems of Services for CYSHCN which was submitted March 2009. Indiana received notification of "Grant Award" on May 22, 2009 with a project start date of June 1, 2009.

CSHCS Care Coordinators linked the participants to a Primary Care Physician (PCP), provided the families with "Tools" to help them prepare for medical visits and educated CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

IN CISS continued its monthly meetings with partners to work on a statewide plan to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community --based and culturally competent; recruited 12 Medical Home Learning Collaborative practices to participate in Quality Improvement activities that will assist the practices transformation to family-centered, community --based and culturally competent Medical Homes; identified and distributed an educational "Medical Home Fact Sheet" for parents, providers and community partners.

The CSHCS program began discussing Medical Homes with the programs participants and assisted in the linkage of each participant to their own Medical Home.

ASK continued to provide on a monthly basis to pediatric residents who are being trained at Indiana University information about community resources and the importance of sharing this

information with families who they will be seeing in practice.

ASK participated on the IN CISS Advisory Committee and also had representation on three of the subcommittees of this project. Initial work was begun to develop surveys for medical professionals and for families about medical home.

CSHCS continued its work to select or develop a brochure for physicians about the medical home concept.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Indiana Community Integrated Systems of Service Advisory Committee (IN CISS) continues its monthly meetings with partners to work on a statewide plan to improve access to quality, comprehensive, coordinated community-based systems of services fo				X
2. The IN CISS Advisory sub-committee titled "Medical Home"; whose focus is to evaluate current systems of care for CYSHCN that promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are fami				X
3. The IN CISS Project recruited 12 Medical Home Learning Collaborative practices to participate in Quality Improvement activities that will assist the practices transformation to family-centered, community –based and culturally competent Medical Homes.				X
4. CSHCS continues to distribute a Medical Home educational "Fact Sheet" for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs		X		
5. ASK continues to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in				X
6. CSHCS continues to facilitate IN CISS Advisory Committee and have ASK participate on the Medical Home subcommittee of this project to further the plan for spreading the medical home concept more broadly in Indiana.				X
7. IN CISS Project continues working with ASK to collect information from families about their understanding of a medical home and identifying steps to take toward furthering the medical home concept in Indiana.				X
8. The CISS sub-committee titled "Medical Home" has been working on its recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana.				X
9. CSHCS continues to develop the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with "Tools" to help them prepare for medical visits and		X		

educate C				
10.				

b. Current Activities
Activities to impact this performance objective include:

IN CISS continues its monthly meetings with partners.

The IN CISS Project recruited 12 Medical Home Learning Collaborative practices.

CSHCS distributes a Medical Home educational "Fact Sheet" for parents; facilitate IN CISS; and work with ASK to further the plan for spreading the medical home concept more broadly in Indiana.

IN CISS Project works with ASK to collect information from families about their understanding of a medical home and identifying steps to take toward furthering the medical home concept in Indiana. ASK continues to connect on a monthly basis with pediatric residents who are being trained at Indiana University.

The CISS Medical Home sub-committee has been working on its recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana.

CSHCS continues to develop the In-house Care Coordination System. The Care Coordinators link participants to a PCP, provide families with "Tools" to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum

c. Plan for the Coming Year
Activities to impact this performance objective include:

The IN CISS will meet monthly with partners to work on the statewide plan to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community --based and culturally competent.

The IN CISS Medical Home sub-committee will evaluate current systems of care for CYSHCN that promote quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community --based and culturally competent and provided through a Medical Home.

The IN CISS Project has been awarded continued funding for FY 2011. The project will continue its work towards implementing Medical Homes throughout the state.

The IN CISS Project will continue to support the recruited 12 Medical Home Learning Collaborative practices participate in Quality Improvement activities that will assist the practices transformation to family-centered, community --based and culturally competent Medical Homes.

CSHCS will distribute a Medical Home educational "Fact Sheet" for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs.

ASK will connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this

information with families who they will be seeing in practice.

CSHCS will facilitate the IN CISS Advisory Committee and have ASK participate on the Medical Home subcommittee of this project to further the plan for spreading the medical home concept more broadly in Indiana.

IN CISS Project will work with ASK to collect information from families about their understanding of a medical home and identifying steps to take toward furthering the medical home concept in Indiana.

The CISS Medical Home sub-committee will make recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana.

CSHCS will continue to enhance the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with "Tools" to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

The CSHCS program will continue to educate participants, providers and community partners on the benefits of a Medical Home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	67	67	62	62
Annual Indicator	63.3	63.3	61.8	61.8	61.8
Numerator					
Denominator					
Data Source				SLAITS	SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	61.8	62	62	63	63

Notes - 2009
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
Actual figures, based upon information in the Agency Claims and Administrative Processing System (ACAPS), of participants in Indiana's CSHCS program who have either private or public health insurance is 91.68% Of that total percentage, 45.67% of participants have some kind of private health insurance and 46.01% have Medicaid.

Activities that impacted this performance objective included:

CSHCS updated the ACAPS system to utilize insurance information for processing electronic pharmacy claims. Electronic Coordination of Benefits (COB) processing of pharmacy claims has been accomplished and we are currently working on electronic COB processing for medical claims.

CSHCS reviewed and followed-up on system reports that were created to identify coordination and benefit issues for electronic pharmacy claims.

CSHCS sent a bulletin to providers which clarified the programs reimbursement methodology as it relates to other insurance and the maximum allowable payment; updated both the Provider and Participant Manual; tracked insurance utilization in ACAPS. This activity allowed for denial of claims for which other insurance coverage is available.

CSHCS monitored the activities and progress of the Health Insurance for Indiana Families Committee, a group of state leaders charged with developing no-or low-cost options to provider services for the uninsured.

CSHCS monitored the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of children and adults who benefit from federal and state health care coverage programs.

CSHCS program provided financial support for a satellite CSHCS office at Riley Children's Hospital. During FY 2009 the Riley CSHCS office performed the following services for CYSHCN and their families:
- Completed 1,881 CSHCS applications and re-evaluations.
- Generated 4,231 Prior Authorizations'.
- Completed 6,040 Travel vouchers.
- Obtained 7,977 additional requests for medical information for the CSHCS program.
- Conducted 1,374 outreach efforts within Riley Hospital.
- Conducted 8,987 CSHCS Program informational sessions to families and providers of Riley Hospital.
- Referred over 1,358 families to support organizations/agencies to facilitate needed services for CYSHCN and their families.

CSHCS granted funds to About Special Kids (ASK), a parent to parent organization and Family-to-Family Health Information Center (F2FHIC) that supports children with special needs and their families. ASK staff members spoke with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and helped families navigate through the complex systems.

ASK offered trainings to families and professionals that outline the various public health insurance programs. Follow-up with an ASK Parent Liaison helped families determine which of these programs will serve their children the best. ASK staff spoke with over 3,142 families in Indiana about health insurance options.

ASK provided training to approximately 100 participants on Understanding Public Health Insurance Options.

CSHCS program sent all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.

CSHCS program assisted families who were eligible for public health insurance options to apply for coverage and follow-up to application decision.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCS will complete the electronic COB process for medical claims which will allow medical claims to be processed more quickly CSHCS continued to review and follow-up on system reports that were created to identify coordination and benefit issues				X
2. CSHCS program provides financial support for a satellite CSHCS office at Riley Children's Hospital. During FY 2010 the Riley CSHCS office will perform the following services for CYSHCN and their families: 1. Complete CSHCS applications and re-evalu		X		
3. CSHCS granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. As a part of this grant, ASK staff members speak with families about a variety of health insurance options		X		
4. ASK currently has representation on the IN C.I.S.S. subcommittee addressing uninsured and underinsured children in our state.				X
5. ASK serves as Indiana's Family to Family Health Information and Education Center (F2FHIC). As Indiana's F2FHIC, ASK has the opportunity to meet quarterly with stakeholders from the state, community and families. The purpose of the F2FHIC is to crea		X		
6. CSHCS program continued to send all participants age 17 years and up information on insurance options to apply for as they age off Hoosier Health wise and their parent's healthcare policies.		X		
7. The IN C.I.S.S. Advisory sub-committee "Access to Adequate				X

Health Insurance" whose focus is to enhance systems of care for CYSHCN around the issues of adequate health insurance made recommendations to coordinate the development, implementation and ev				
8. The CSHCS program became a "Registered Agency" with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.				X
9. The IN CISS Project staff provides TA and resource materials to the 12 Medical Home Learning Collaborative practices to assist both the provider and patient's insurance needs. The project is using the Sunny Start Financial Fact Sheets to assist in t		X		
10. The IN CISS Project parent consultants are working with both the CSHCS Claims and Provider Relations sections to evaluate CSHCS current systems relating to insurance needs and payment and identifying areas of opportunity for both the provider and the				X

b. Current Activities

CSHCS is completing the electronic COB process for medical claims; continuing to review and follow-up on system reports relating to electronic pharmacy claims; continuing to update the Provider and Participant Manuals; tracking insurance utilization in ACAPS; monitoring the activities and progress of the Health Insurance for Indiana Families Committee; monitoring the activities and progress of Covering Kids & Families (CKF).

CSHCS funded ASK to help families navigate variety of health insurance options. ASK serves as Indiana's Family to Family Health Information and Education Center (F2FHIC). As Indiana's F2FHIC, ASK has the opportunity to meet quarterly with stakeholders from the state, community and families. The purpose of the F2FHIC is to create health care change in the state.

ASK has revised its public health insurance training. The curriculum will be publicized and offered to both families and professionals with a "menu" of topics that the requesting party can select from to allow for the training to be customized.

CSHCS became a "Registered Agency" with the DFR to allow access to their Web Portal to verify participants Medicaid/HHW status.

IN CISS staff provide TA and resource materials to the 12 Medical Home Learning Collaborative practices. The project is using the Sunny Start Financial Fact Sheets.

IN CISS parent consultants are working with both the CSHCS Claims and Provider Relations sections to evaluate CSHCS current systems.

c. Plan for the Coming Year

CSHCS will continue updating Provider and Participant manuals; enhancing the ACAPS system; reviewing and following-up on system reports that were created to identify coordination of benefit issues for electronic pharmacy claims; sending bulletins to providers which clarifies the programs reimbursement methodology; tracking insurance utilization in ACAPS.

CSHCS will continue to monitor the activities and progress of the Health Insurance for Indiana Families Committee and the activities and progress of CKF.

CSHCS program will provide financial support for a satellite CSHCS office at Riley Children's Hospital.

CSHCS will grant funds to ASK for the purpose of having ASK staff speak with families about a variety of health insurance options and help families navigate through these complex systems.

ASK will serve on the IN CISS Insurance subcommittee addressing uninsured and underinsured children and will work with the committee to develop a plan of action related to this topic.

ASK will serve as Indiana's Family to Family Health Information and Education Center (F2FHIC). As Indiana's F2FHIC, ASK has the opportunity to meet quarterly with stakeholders from the state, community and families.

The new ASK public health insurance training curriculum will continue to be publicized and offered to both families and professionals in the coming year. The new curriculum features a "menu" of topics that the requesting party can select from so that the training can be customized.

CSHCS program will send all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.

The IN CISS will work to support and develop services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community --based and culturally competent.

The CISS Sub-committee, Access to Adequate Health Insurance, will complete recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the adequate health insurance.

The IN CISS Project staff will provide TA and resource materials to the 12 Medical Home Learning Collaborative practices to assist in meeting both the provider and patient's insurance needs. The project is using the Sunny Start Financial Fact Sheets to assist in this activity.

The IN CISS Project parent consultants will work with both the CSHCS Claims and Provider Relations sections to evaluate CSHCS current systems relating to insurance needs and payment and identifying areas of opportunity for both the provider and the participant.

The CSHCS program will continue as a "Registered Agency" with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	95	95
Annual Indicator	79.5	79.5	94.3	94.3	94.3
Numerator					
Denominator					
Data Source				SLAITS	SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	94.3	95	95	96	96

Notes - 2009
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
Activities that impacted this Performance Objective included:

CSHCS continued providing In-house Care Coordination to the CSHCS participants; the Care Coordinators assessed the participants and their families needs and made appropriate referrals, linked the participants to a Primary Care Physician (PCP), provided the families with "Tools" to help them prepare for medical visits and educated the participants and their families on the Medical Home Concept where families and physicians work together to identify and access the medical and non-medical services needed to help children and their families reach their maximum potential.

CSHCS continued its funding and collaborative partnership with ASK and its statewide network of family-to-family peer support. ASK continued to update and add new resources to its online resource directory; during this past year ASK added a for profit component to the directory (previously, the directory only included nonprofit resources). In this section, for profit companies, who are specifically addressing the needs of children with special health care needs, are listed for a fee. A disclaimer is offered to families so that they know that the organization does not endorse any specific for profit entities. During FY 2009 the ASK Resource Directory listed over 2,057 resources and had 17,191 visitors to the site. ASK has assisted over 22,212 families access appropriate community resources during FY 2009.

With funding assistance from ISDH, ASK continued to update the Marion County community resource pads and also the statewide community resource poster that have been distributed to health care settings, and through various information fairs throughout the state. Key community resources were selected for listing on these materials and they were made "user-friendly" so that they could easily be utilized.

CSHCS continued to meet with The Indiana Community Integrated Systems of Service Advisory

Committee (IN C.I.S.S.) This statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families worked together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community--based and culturally competent.

The IN CISS sub-committee titled "Organization of Community Services for Easy Use By Families" (whose focus is to enhance systems of care for CYSHCN around the issues of community-based service systems that are organized so families can use them easily) made recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the above goal. These recommendations were used to apply for federal funding to support system improvement for CYSHCN and their families. Indiana was one of six states to be awarded this federal funding from HRSA/MCHB and began working on systems improvement on June 1. 2009.

Title V maintains an 800 Family Help Line with V/TDD capabilities and bilingual support that refers families to community-based services.

CSHCS provided current community based-training to First Steps providers and Division of Family Resources (DFR) staff to promote improved systems access, and to improve the organization and delivery of services to children with special health care needs.

CSHCS reimbursed families for in-state and out-of-state transportation of CSHCS participants to medical facilities for services.

CSHCS provided outreach to Neonatal Intensive Care Units (NICU), and maintained and provided lists of primary care physicians participating in the CSHCS program.

CSHCS promoted Single Points of Entry (SPOE) early intervention sites, and uses local Offices of Family Resources to take CSHCS applications.

CSHCS continued using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintained an information and application site at Riley Hospital for Children.

CSHCS published a bi-yearly (Summer and Winter) newsletter which included informative articles and program updates that affect participants (i.e., policy changes, new mileage reimbursement rates, etc.).

CSHCS collaborated with the Sunny Start Initiative to develop Informational Fact Sheets on over 25 resource topics available to families on the Early Childhood Meeting Place website

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCS continued to develop the In-house Care Coordination System. The Care Coordinators assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families wi		X		
2. CSHCS continued to fund and collaborate with About Special Kids (ASK) and its statewide network of family-to-family peer support.		X		
3. ASK continued to update existing resources in its online directory and add new resources as they become available		X		

4. ASK continues to serve families on a one on one basis and will continue to provide follow-up to these families to insure that they are accessing the appropriate resources.		X		
5. ASK continues to seek funding to update additional counties' community resource cards.		X		
6. The Indiana Community Integrated Systems of Service Advisory Committee (IN CISS) continues working with the statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs				X
7. The IN CISS sub-committee titled "Organization of Community Services for Easy Use By families" (whose focus is to enhance systems of care for CYSHCN around the issues of community-based service systems that are organized so families can use them easi				X
8. . The IN CISS Project received federal grant funding to work on system improvement for CYSHCN and their families. The project works with providers, parents and family members of CYSHCN to provided TA and resource information to assist all parties				X
9. The IN CISS Project employs two parent consultants who provide the parent perspective on improvement efforts in the area of organized community-based service systems that are easy for CYSHCN and their families to access.				X
10. MCH maintains an 800 Family Help Line with V/TDD capabilities and bilingual support and refers families to community-based services. CSHCS provides current community based-training to First Steps providers and Division of Family Resources (DFR) st		X		

b. Current Activities

CSHCS continued to develop the In-house Care Coordination System and to fund and collaborate with ASK. ASK continued to update its online directory; serve families and provide follow-up. ASK continues to seek funding to update additional counties' community resource cards.

IN CISS workswith the statewide Advisory Committee and a IN CISS sub-committee continues to coordinate the development, implementation and evaluation of the State Integrated Community Services. IN CISS also is working on system improvement.

Title V maintains an 800 Family Help Line with V/TDD capabilities and bilingual support that refers families to community-based services.

CSHCS provides current community based-training to First Steps providers and Division of Family Resources (DFR) staff to promote systems development, and to improve the organization and delivery of services to children with special health care needs; continues to reimburse families transportation to medical facilities; provides outreach to NICUs; promotes Single Points of Entry early intervention sites; uses a customer service representative at Riley Hospital for Children; publishes a summer and winter newsletter; maintains a CSHCS website to provide real-time information sharing; and collaborates with the Sunny Start Initiative to develop Informational Fact Sheets on over 25 resource topics available to families on the Early Childhood Meeting Place website.

c. Plan for the Coming Year

CSHCS will utilize the In-house Care Coordination System to assess the participants and their families' needs; make appropriate referrals; link participants to a PCP; provide families with "Tools" to help them prepare for medical visits; and educate CSHCS participants and their families on the Medical Home Concept.

CSHCS will fund and collaborate with ASK. ASK will continue to update existing resources in its online directory; serve families on a one-on-one basis; provide follow-up; and seek funding to update additional counties' community resource cards.

The IN CISS will work with the statewide Advisory Committee to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community--based and culturally competent.

The IN CISS' sub-committee, "Organization of Community Services for Easy Use by Families", will work to coordinate the development, implementation and evaluation of the State Integrated Community Services Plan to achieve the above goal.

The IN CISS Project will receive federal grant funding for FY 2011 to work on system improvement for CYSHCN and their families. The project will continue to work with providers, parents and family members of CYSHCN to provide TA and resource information to improve the organization of community-based service systems.

The IN CISS Project will employ two parent consultants who will provide the parent perspective on improvement efforts in the area of organized community-based service systems that are easy for CYSHCN and their families to access.

CSHCS will provide current community based-training to First Steps providers and Division of Family Resources (DFR) staff to promote systems development, and to improve the organization and delivery of services to children with special health care needs; reimburse families for transportation to medical facilities for services; provide outreach to NICUs; maintain and provide lists of primary care PCPs participating in the CSHCS program; promote Single Points of Entry (SPOE) early intervention sites; use a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children; publish a summer and winter newsletter which includes informative articles and any program updates that affect participants; communicate with the programs participants, providers and community partners via e-mail and the CSHCS website to provide real-time information sharing on an ongoing basis. CSHCS will also continue to collaborate with the Sunny Start Initiative to develop additional Informational Fact Sheets available to families on the Early Childhood Meeting Place website.

Title V will continue to maintain an 800 Family Help Line with V/TDD capabilities and bilingual support that refers families to community-based services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6	6	6	41.5	41.5
Annual Indicator	5.8	5.8	41.1	41.1	41.1
Numerator					
Denominator					
Data Source				SLAITS	SLAITS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	41.1	42	42	43	43

Notes - 2009
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2008
The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments
CSHCS distributed the Transition Manual to 100% of CSHCS participants ages 14 years and older and at health and transitional fairs.

CSHCS provided financial support to the Center for Youth and Adults with Conditions of Childhood (CYACC) Bridging Team. The centers focus is on transitional health care for youth with special health care needs. It is through Indiana University (IUPUI) School of Medicine Department of Pediatrics. The objectives for this project includes: 1) assessing current strength & weaknesses in health care transitions from pediatric to adult care and subspecialty care providers who wish to participate in transitional health care; 2) establishing a data base of primary care and subspecialty care providers who which to participate in transitional health care; 3) developing desired education methods for families & physicians to address needs in preparation and through transition; 4) providing resources and information for youth , families and physicians through transition; 5) creating a demonstration model for primary and consultative transition health care.

IN FY 2009 the center provided services to over 319 patients referred from physicians, community agencies and families. All patients had health care assessments and training in future health care issues including medical management plans, insurance change, provider transfers, and self-management activities. The assessment produced an Individual Health Assessment Plan (IHAP) and portable medical summary to use with future providers.

CSHCS staff received ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult health care, work and independence. Information was received through TA trainings and informational materials provided by the Healthy & Ready to Work (HRTW) National Center and CSHCS partnership with Indiana's Center for Youth & Adults with Conditions of Childhood(CYACC) transition program.

CSHCS continued to meet with IN CISS. his statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families worked together to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community--based and culturally competent.

The IN CISS' sub-committee, "Transitions to Adult Health Care, Work and Independence", recommended the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the above goal. These recommendations were used to apply for federal funding to support system improvement for CYSHCN and their families. Indiana was one of six states to be awarded this federal funding from HRSA/MCHB and began working on systems improvement on June 1, 2009.

CSHCS and the CYACC Transition Clinic continued to develop transition resource materials for clients and training for providers. The CYACC Transition Project continued work with health care providers statewide on transitioning youth with special health care needs to adult care. Materials and tools developed at the CYACC transition clinic continued to be distributed to other providers. CSHCS communicated with the programs participants, providers and community partners via e-mail and the CSHCS website to provide real-time information sharing on an ongoing basis relating to Transition to adult healthcare, work and independence.

CSHCS continued to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.

CSHCS continued to work with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals to adult healthcare, work and independence.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCS continues to distribute the Transition Manual to 100% of the CSHCS participants ages 14 years and older.		X		
2. CSHCS continues to distribute the Transition Manual at health and transitional fairs attended as an exhibitor.		X		
3. CSHCS staff continues to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult health care, work and				X

independence, Through TA trainings and informational materials provided b				
4. CSHCS continues to provide financial support to the Center for Youth and Adults with Conditions of Childhood (CYACC) Bridging Team. The centers focus is on transitional health care for youth with special health care needs. It is through Indiana Uni		X		
5. CSHCS continues to meet with The Indiana Community Integrated Systems of Service Advisory Committee (IN C.I.S.S.) This statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health				X
6. The IN CISS sub-committee titled "Transitions to adult health care, work and independence" (whose focus is to enhance systems of care for CYSHCN around the issues of transition) has been working to coordinate the development, implementation and evalu				X
7. The IN CISS Project has recruited youth with special healthcare needs and their families to form an Advisory Committee to provide their perspective on transition issues. The members are provided a stipend for their participation on the committee.				X
8. CSHCS continues to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.		X		
9. CSHCS and the CYACC Transition Clinic continued to develop transition resource materials for clients and training for providers.		X		
10. CSHCS continues to work with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.				X

b. Current Activities

CSHCS distributes the Transition Manual to 100% of the CSHCS participants ages 14 years and older; continues to receive ongoing training and updates regarding transitioning CSYHCN to adult health care, work and independence.

CSHCS provides financial support for CYACC Bridging Team; to meet with IN CISS; and CSHCS continues to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.

The IN CISS Project has recruited youth with special healthcare needs and their families to form an Advisory Committee to provide their perspective on transition issues.

CSHCS and the CYACC Transition Clinic continued to develop transition resource materials for clients and training for providers. CSHCS continues to work with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.

The CYACC Transition Project is working with health care providers statewide on transitioning youth with special health care needs to adult care.

Materials and tools developed at the CYSHCN transition clinic continue to be distributed to other

providers. CSHCS communicates electronically with the program's participants, providers and community partners to provide real-time information sharing on an ongoing.

c. Plan for the Coming Year

CSHCS will distribute the Transition Manual to 100% of the CSHCS participants ages 14 years and older.

CSHCS will distribute the Transition Manual at health and transitional fairs attended as an exhibitor.

CSHCS staff will receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult health care, work and independence, Through TA trainings and informational materials provided by the Healthy & Ready to Work (HRTW) National Center and CSHCS partnership with Indiana's Center for Youth & Adults with Conditions of Childhood(CYACC) transition program.

CSHCS will continue to provide financial support to CYACC Bridging Team through Indiana University (IUPUI) School of Medicine Department of Pediatrics.

CSHCS will continue to meet with The Indiana Community Integrated Systems of Service Advisory Committee (IN CISS) This statewide Advisory Committee works to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community--based and culturally competent.

The IN C.I.S.S. sub-committee titled "Transitions to adult health care, work and independence" (whose focus is to enhance systems of care for CYSHCN around the issues of transition) will continue working to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the above goal. On-going federal grant funding has been approved for FY 2011. Activities to accomplish this goal has CYACC marketing, providing tools, resources and Educational Office Visits (EOV) to build partnerships with community physicians and/or their healthcare teams to assist in meeting the transition needs of CYSHCN in their practices.

The IN CISS Project has recruited youth with special healthcare needs and their families to form an Advisory Committee to provide their perspective on transition issues. The members will continue to receive a stipend for their participation on the committee.

CSHCS will publish a bi-yearly newsletter to CSHCN families and participants; to develop transition resource materials for clients and training for providers; to work with interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.

The CYACC Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.

Materials and tools developed at the CYSHCN transition clinic will continue to be distributed to other providers.

CSHCS will communicate with the programs participants, providers and community partners via e-mail and the CSHCS website to provide real-time informational sharing on an ongoing basis relating to Transition to adult healthcare, work and independence.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	81	81	84	84	85
Annual Indicator	81	83.2	76.8	89.1	89.1
Numerator					
Denominator					
Data Source				ISDH - Imm. Pgm	ISDH - Imm. Pgm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	89.5	90	90.5	91	91.5

Notes - 2009
Figure provided without numerator or denominator.

Source of data: ISDH Immunization program.

Notes - 2008
Figure provided without numerator or denominator.

Source of data: ISDH Immunization program.

Notes - 2007
This represents the low end of the 95% confidence level rather than the median and thus appears to be a drop when actually it is not. The original provisional figure of 84 has been corrected to match the final data provided by the IDH immunization program.

Source of data: ISDH Immunization program.

a. Last Year's Accomplishments
Activities that impacted this Performance Objective include:

The Immunization Program provided vaccines to Maternal and Child Health (MCH) sites enrolled in the Vaccines for Children (VFC) program.

The Immunization Program conducted VFC and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH worked with the Immunization Program to increase the number of sites using the Children

and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.

MCH Health Systems Development staff attended the Indiana Immunization Coalition and participate in its activities.

MCH worked with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

ISDH conducted a television media campaign with State Health Commissioner, Dr. Judith Monroe, urging families to have their children vaccinated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Immunization Program will conduct Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled Maternal and Child Health (MCH) sites to assess implementation of VFC policies.				X
2. MCH will work with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.				X
3. MCH will coordinate with the Immunization Program to provide educational opportunities for WIC program staff.			X	
4. MCH Health Systems Development staff will attend the Indiana Immunization Coalition and participate in its activities.				X
5. MCH will work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities to impact this Performance Objective include:

The Immunization Program conducts VFC and AFIX visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH works with the Immunization Program to increase the number of sites using the CHIRP reminder/recall feature.

MCH coordinates with the Immunization Program to provide educational opportunities for WIC program staff.

MCH Health Systems Development staff attends the Indiana Immunization Coalition and participate in its activities.

MCH works with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

The ISDH Immunization Division Director implemented a policy allowing Federally Qualified

Community Health Centers (FQCHCs) to delegate authority to local health departments for immunization of underinsured children under the VFC program.

c. Plan for the Coming Year
Activities that will impact this Performance Objective include:

The Immunization Program will conduct VFC and AFIX visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH will work with the Immunization Program to increase the number of sites using the CHIRP reminder/recall feature.

MCH will coordinate with the Immunization Program to provide educational opportunities for WIC program staff.

MCH Health Systems Development staff will attend the Indiana Immunization Coalition and participate in its activities.

MCH will work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	19.5	19	20.1	20
Annual Indicator	20.5	20.8	22.1	20.4	20
Numerator	2757	2808	2955	2780	
Denominator	134457	134753	133975	136430	
Data Source				ISDH - ERC	ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19.8	19.6	19.4	19.2	19

Notes - 2009
Figure projected from past data.

Source of past data: ISDH ERC

Notes - 2008
Numerator calculated based on the provided denominator and the rate.

Source of past data: ISDH ERC

Notes - 2007
ERC provided updated provisional data for rate and numerator; denominator calculated from those figures

Source of data: ISDH ERC.

a. Last Year's Accomplishments
The state adolescent health coordinator (SAHC) submitted all necessary documentation and paperwork to ensure continuation of federal Abstinence Education Block Grant funds through fiscal year 2013. (Grant application was approved for fiscal years 2009-2013). However, funding for this federal program was terminated as of June 30, 2009.

SAHC continued to oversee teen pregnancy prevention programs supported with state funds. These community-based organizations also received training and technical assistance from the SAHC regarding program implementation, program adaptation and evaluation.

SAHC monitored the progress and effectiveness of the statewide abstinence media campaign and disseminated educational materials to community-based organizations, teens, and parents. SAHC oversaw the development and launch of a revised Indiana RESPECT website by July 2009.

SAHC partnered with other divisions within the Indiana State Department of Health to assist in the administration of the 2009 Youth Risk Behavior Survey (YRBS) which provides Indiana with data regarding sexual behaviors among Hoosier adolescents.

SAHC facilitated the Indiana Coalition to Improve Adolescent Health. The coalition released the state's first adolescent health plan in May 2009. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.

SAHC served as a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy, STD's, and HIV among adolescents and translate this research into user-friendly materials to disseminate to the field.

SAHC promoted the 2009 National Day to Prevent Teen Pregnancy by coordinating announcements regarding the National Day to be sent to all school superintendents and principals throughout the state with the help of the Indiana Department of Education.

SAHC attended a sexual health summit for adolescents in April 2009.

ISDH funded three school-based adolescent health clinics to provide services to students. Among other things, the clinics are required to provide education about teen pregnancy prevention as well as provide direct care for or referrals to pregnant students. Most clinics provide in-class education on the topic of pregnancy prevention. SAHC is the consultant for the clinics and provides technical assistance and educational materials to the clinics.

SAHC partnered with the Office of Women's Health at the Indiana State Department of Health to produce a special insert dedicated to preventing unplanned pregnancy (including teen pregnancies) that was featured in the January 2009 edition of Indianapolis Woman magazine.

SAHC participated on several conference calls and webinars which discussed teen pregnancy prevention and provided technical assistance on a variety of topics including how to choose the right curriculum for your priority population, how to evaluate your program, how to market your program and engage your priority population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State adolescent health coordinator (SAHC) will submit an application for the anticipated federal funds for teen pregnancy prevention out of the newly created Office of Adolescent Health.			X	X
2. SAHC will partner with other divisions within the Indiana State Department of Health (ISDH) to review and analyze data from the 2009 Youth Risk Behavior Survey (YRBS). SAHC will also ensure dissemination of the data from this survey, including presen		X	X	
3. SAHC will facilitate the ICIAH. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.				X
4. SAHC will oversee SFY 2010-2011 Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) community-based grant program application and review process, including updating the grant application and holding a technical assistanc	X	X	X	
5. SAHC will provide content updates on a quarterly basis to the Indiana RESPECT website in order to provide visitors with the latests data, information, and research on teen pregnancy prevention. SAHC will ensure the dissemination of educational materi				X
6. SAHC will promote the 2010 National Day to Prevent Teen Pregnancy. SAHC will work internally with other programs at ISDH and collaborate with the Indiana Department of Education (IDOE) to share information regarding this initiative with schools, teac			X	
7.				
8.				
9.				
10.				

b. Current Activities

Oversee the SFY 2010-2011 Indiana RESPECT community-based grant program application and review process.

Provide content updates on a quarterly basis to the Indiana RESPECT website and ensure dissemination of educational materials to community-based organizations, teens, and parents.

Submit an application for the anticipated federal funds for teen pregnancy prevention out of the newly created Office of Adolescent Health.

Partner with other divisions within the ISDH to review and analyze data from the 2009 YRBS and ensure dissemination of the survey data.

Facilitate the Indiana Coalition to Improve Adolescent Health and continue to fund three school-based adolescent health clinics to provide services to students.

Promote the 2010 National Day to Prevent Teen Pregnancy and work internally with other programs at the ISDH and collaborate with the Indiana Department of Education to share information regarding this initiative with schools, teachers, community members, and grantees of Indiana RESPECT.

Continue to serve on the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy.

Oversee grants to local organizations to provide technical assistance and training on preventing teen pregnancy, including the hosting of conferences, training and webinars; providing one-on-one technical assistance for programs; and focus groups with adolescents about the barriers to preventing teen pregnancies.

c. Plan for the Coming Year
SAHC will participate on conference calls and webinars which address the topic of preventing teen pregnancies.

SAHC will continue to serve as a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy.

SAHC will promote the 2010 National Day to Prevent Teen Pregnancy. SAHC will work internally with other programs at the Indiana State Department of Health and collaborate with the Indiana Department of Education to share information regarding this initiative with schools, teachers, community members, and grantees of Indiana RESPECT.

SAHC will facilitate the Indiana Coalition to Improve Adolescent Health. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.

SAHC will provide content updates on a quarterly basis to the Indiana RESPECT website in order provide visitors with the latest data, information, and research on teen pregnancy prevention. SAHC will ensure the dissemination of educational materials to community-based organizations, teens, and parents.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	46	47	48	49	50
Annual Indicator	44.5	47.1	48.7	49	50
Numerator					
Denominator					
Data Source				ISDH -	ISDH - Oral

				Oral Hlth	Hlth
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
Projected based on last year's information from ISDH Oral Health program.

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This means that, based on our revised projection, we met our goal for 2008.

Notes - 2008
Projected based on last year's information from ISDH Oral Health program.

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This means that, based on our revised projection, we met our goal for 2008.

Notes - 2007
Projected based on last year's information from ISDH Oral Health program.

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This means that, based on our revised projection, we met our goal for 2007.

a. Last Year's Accomplishments
Activities that impacted this Performance Objective included:

Oral Health Program (OHP) utilized MCH grant dollars to enhance and support sealant projects already in existence in Title I schools by current dental mobile providers.

OHP promoted community-based dental sealant programs, among existing programs, and continued to collaborate with the IU School of Dentistry Community Dentistry's Seal Indiana sealant program to develop specific pilot school programs to help increase sealant placement to third graders.

OHP encouraged dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to eliminate disparities in preventative services rendered.

OHP continued to consult with the Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory Panel on oral health issues by attending quarterly meetings or as needed to improve access to quality oral health care.

The State Oral Health Director (SOHD) collaborated with the Center for Health Policy and the Indiana University School of Dentistry (IUSD) on a HRSA funded project that, set up the Statewide Planning Council, conducted a statewide oral health needs assessment, identified priority oral health needs, and developed a preliminary strategic oral health plan.

OHP helped communities gain designation as a Dental HPSA.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OHP will utilize grant dollars to enhance and support sealant projects already in existence in Title I schools by current dental mobile providers.	X			
2. OHP will promote community-based dental sealant programs, among existing programs and will continue to collaborate with the IUSD Community Dentistry's sealant placement program to develop specific pilot school programs.				X
3. OHP will encourage dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.				X
4. OHP will continue to consult with the Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory Panel on oral health issues by attending quarterly meetings or as needed.				X
5. OHP will collaborate with partners such as the IUSDIndiana Dental Association, Indiana Dental Hygienists Association, Indiana Rural Health Association, Indiana Primary Health Care Association and other partners in the state.				X
6. OHP will help communities gain designation as Dental HPSA and collaborate with ISDH Primary Care Director to accomplish this.				X
7. OHP will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).				X
8.				
9.				
10.				

b. Current Activities

SOHD is seeking funding from CDC to enhance the infrastructure (personnel) of the State OHP, and to plan for and begin implementing specific goals in the Strategic Oral Health Plan, such as expanding school-based dental sealant programs.

OHP is seeking grant dollars or other funding to enhance and support sealant projects already in existence in Title I schools by current mobile providers.

OHP is promoting community-based dental sealant programs, among existing programs, and will continue to collaborate with the IUSD Community Dentistry's Seal Indiana sealant program to help increase sealant placement to third graders.

OHP is encouraging dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services

rendered.

OHP continues to consult with the Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory Panel on oral health issues by attending quarterly meetings.

OHP collaborates with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

c. Plan for the Coming Year

OHP of the Indiana State Department of Health (ISDH) plans to expand its personnel to help meet its growing demands to continue to collect and assess data on the oral health status of the residents of Indiana.

SOHD will work with other ISDH personnel and partners to identify components of the Strategic Oral Health Plan than can be implemented with available resources.

SOHD will work with the Oral Health Task Force (OHTF) to evaluate and transition it into an Oral Health Coalition (OHC).

SOHD will work with the OHTF (or the OHC) to use the Strategic Oral Health Plan as the foundation upon which to develop an official Indiana Oral Health Plan (IOHP), and to issue recommendations for state oral health priorities.

SOHD will work with partners to obtain funding to help meet the state's highest oral health priorities, including the expansion of school-based dental sealant programs.

OHP will seek grant dollars or other funding to enhance and support sealant projects already in existence in Title I schools by current mobile providers.

OHP will promote community-based dental sealant programs, among existing programs, and will continue to collaborate with the IUSD Community Dentistry's Seal Indiana sealant program to develop specific pilot programs to help increase sealant placement to third graders.

OHP will encourage dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

OHP will continue to consult with the OMPP and the Dental Advisory Panel on oral health issues by attending quarterly meetings.

OHP and ISDH will collaborate with the IUSD in a specific project to help a community in Indiana gain designation as a Dental HPSA, and continue to help all eligible communities gain designation as a Dental HPSA.

OHP will collaborate with the Indiana Rural Health Association (IRHA) and the Indiana Primary Health Care Association (IPHCA) to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	3.4	3.2	3	2.8
Annual Indicator	3.3	3.5	3.4	3.5	3.4
Numerator	44	46	44	46	
Denominator	1326607	1301093	1310331	1311912	
Data Source				ISDH - ERC	ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.3	3.2	3.1	3	3

Notes - 2009
Projected based on data provided in previous years.

Source of data: ISDH - ERC

Notes - 2008
Source of data: ISDH - ERC

Corrected: would be 3.3 but application would not let us correct the figure for 2008.

Notes - 2007
Fluctuating figure; expected to decrease next year. Estimated (projected) to be 3.2. Actual numerator provided; denominator will be corrected with information from the USCB site. Temporarily denominator calculated from projected rate and actual numerator.

Source of data will be US Census Bureau; ISDH ERC.

a. Last Year's Accomplishments
Activities that impacted this Performance Objective included:

Use of child restraints is the most effective tool. In July 2009 the child passenger law was amended to remove exemptions for out of state drives. Now the only exemptions are for vehicles manufactured without restraints. Disabled children who cannot be restrained safely must carry a letter from their physician exempting them from restraint but in most instances restraints are modified for such children rather than exempting them from restraint.

Indiana State Department of Health (ISDH) funded a part-time epidemiologist for the ISDH Injury Prevention Program through August 31, 2009.

Maternal and Child Health (MCH) Medical Director and Perinatal and Child Health Nurse Consultant periodically met with representatives of the State Child Death Review Program to find ways to increase collaboration.

ISDH coordinated periodic meetings of the Injury Prevention Advisory Council.

ISDH completed the work on the updated version of "Injuries in Indiana" data report that has an entire section which focuses on motor vehicle crashes and issues related to adolescent driving.

ISDH coordinated information on preventing deaths and injuries from teen motor vehicle crashes as one topic area in the Indiana Adolescent Health Plan.

ISDH promoted automotive safety through participation in relevant local/state programs.

The Indiana Criminal Justice Institute in partnership with Indiana University Center for Criminal Justice Research Center gathered data and published 2009 Indiana Traffic Safety Fact Sheets and Indiana Crash Fact book. (author Dona Sap) @ http://www.in.gov/cji/files/Children_2008.pdf

Indiana Criminal Justice Institute provided grants to the Automotive Safety Program (ASP), which funds permanent fitting stations for infant and child car seats and booster seats. According to their fiscal year 2009 report, there are 5 local health departments that are included in their total of 121 permanent fitting stations.
According to their annual report, ASP inspected a total of 9,797 seats and replaced 4,204 seats among the fitting stations.

MCH staff explored how to increase involvement in Injury Prevention activities and dissemination of information from the Child Death Review Process.

ISDH was awarded funding from the 2010 Primary Prevention Block Grant to conduct a State and Territorial Injury Prevention Directors Association state wide needs assessment and develop a statewide Injury Prevention Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Indiana State Department of Health (ISDH), through the Division of Primary Care, continues to fund a part-time epidemiologist for th ISDH Injury Prevention Program through August 31, 2010.				X
2. MCH Medical Director and Perinatal and Child Health Nurse Consultant meet with representatives of the State Child Death Review Program to find ways to increase collaboration.				X
3. ISDH coordinates periodic meetings of the Injury Prevention Advisory Council.				X
4. ISDH completed updated "Injuries in Indiana" data report that has an entire section which focuses on motor vehicle crashes but not specific to adolescent driving.				X
5. ISDH continues to work with the Injury Prevention Advisory Council to ensure information is shared with internal and external partners concerning programs and activities involving injury prevention.				X
6. ISDH continues to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the Indiana Adolescent Health Plan (pages 46-48).				X
7. ISDh will schedule a State and Territorial Injury Prevention Director's Association site visit during 2010 to conduct a needs assessment to establish appropriate focus areas for the Injury				X

Prevention Program.				
8. Survey of hospitals in west central Indiana utilizing the needs assessment tools will be re-contracted. A person has been identified to redo the assessment and will hopefully start soon. The discussion/drafting of trauma center designmation rules can				X
9. The Indiana Criminal Justice Institute in partnership with Indiana University Center for Criminal Justice Research Center gathers data and published the 2009 Indiana Traffic Safety Fact Sheets and Indiana Crash Fact Book.				X
10. The Indiana Criminal Justice Institute provides grants to the Automotive Safety Program (ASP), which funds permanent fitting stations for infant and child car seats and booster seats.		X		

b. Current Activities

ISDH, through the Division of Primary Care, continues to fund a part-time epidemiologist for the ISDH Injury Prevention Program through August 31, 2010. ISDH coordinates periodic meetings of the Injury Prevention Advisory Council and completed updated "Injuries in Indiana" data report that has an entire section which focuses on motor vehicle crashes but not specific to adolescent driving.

ISDH continues to work with the Injury Prevention Advisory Council to share information with partners concerning programs and activities; and to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the Indiana Adolescent Health Plan.

ISDH completed a State and Territorial Injury Prevention Director's Association site visit to conduct a needs assessment to establish appropriate focus areas for the Injury Prevention Program.

MCH Medical Director and Perinatal and Child Health Nurse Consultant meet with representatives of the State Child Death Review Program to find ways to increase collaboration.

The Indiana Criminal Justice Institute in partnership with Indiana University Center for Criminal Justice Research Center gathers data and published 2009 Indiana Traffic Safety Fact Sheets and Indiana Crash Fact book.

Indiana Criminal Justice Institute provides grants to the Automotive Safety Program (ASP), which funds 121 permanent fitting stations for infant and child car seats and booster seats through 5 local health departments

c. Plan for the Coming Year

ISDH will continue to work with the Injury Prevention Advisory Council to ensure information is shared with internal and external partners concerning programs and activities involving injury prevention.

ISDH will continue to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the Indiana Adolescent Health Plan.

ISDH will continue to promote automobile safety through participation in relevant local/state programs.

The Indiana Criminal Justice Institute in partnership with Indiana University Center for Criminal Justice Research Center will continue to gather data and publish 2009 Indiana Traffic Safety Fact Sheets and Indiana Crash Fact book.

Indiana Criminal Justice Institute will continue to provide grants to ASP, which funds 121 permanent fitting stations for infant and child car seats and booster seats through 5 local health departments:

-Boone County Health Department, Lebanon
-Elkhart County HD, Elkhart
-Henry County HD, New Castle
-Marion County HD, Indianapolis
-Spencer County HD, Rockport

ISDH will participated in establishing priorities for the Injury Prevention Program based on the State and Territorial Injury Prevention Association's 2010 needs assessment.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35	31	35	36
Annual Indicator	29.2	30.2	34.6	35.4	36
Numerator					
Denominator					
Data Source				US CDC Report	US CDC Report
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37	38	39	40	41

Notes - 2009
US CDC Report will be updated prior to end of 2010. Projection used until then based on trend analysis.

Notes - 2008
Data Source: US CDC Report

Notes - 2007
Note: 2006 figure changed by CDC to 37.2; data unable to be changed for 2006 in application.

Source of data: US CDC report.

a. Last Year's Accomplishments
The Maternal and Child Health (MCH)-funded State Breastfeeding Coordinator (SBC) actively worked with local coalitions all over the state, increasing their numbers from 8 to 32. Additionally, she conducted training sessions for local coalitions wishing to utilize The Business Case for Breastfeeding and has served as the resource for all related questions and issues in the state. She attended and exhibited at numerous local and state and meetings, including the state

meetings of the Society for Human Resource Managers, and the Indiana Chapter of the American College of Obstetrician/Gynecologists (ACOG).

Indiana Perinatal Network (IPN) held a training opportunity in November 2008, in accordance with HRSA specifications, for individuals wishing to actively assist with HRSA's Business Case for Breastfeeding program to outreach to employers and employees.

The Indiana Breastfeeding Alliance (IBFA) formalized bylaws and elected new officers. A new action list was developed at the February 2009 meeting with the goals of pursuing insurance coverage of lactation services and supplies, and a formal state registry of International Board Certified Lactation Consultants (IBCLCs). The IBFA also officially recognized the International Breastfeeding Symbol and began using it on their materials.

IPN and the Division of Nutrition and Physical Activity (DNPA) updated their websites, including expanded sections on breastfeeding information, links and resources. The SBC began distributing a monthly Breastfeeding Update e-newsletter.

The Indiana Black Breastfeeding Coalition (IBBC) continued to 'promote, empower, embrace, and encourage mothers, fathers, infants, and family members in the African American community. Additionally, with their assistance, a second IBBC was formed in northern Indiana.

Women, Infants, and Children (WIC) provided a five day Lactation Specialist Course, open to WIC staff and non WIC community partners. There were 70 participants.

WIC conducted six days (12 sessions) of 'WIC: Building Bridges for Breastfeeding Durations' at Indiana Hospitals. There were an estimated 300 in attendance total. They also conducted an exam cram course for lactation consultants and exam candidates; 40 WIC and non-WIC participants attended.

The ISDH DNPA received a large grant from the CDC, in which one of the six target areas is to increase breastfeeding support. Their implementation of the grant, called The Indiana Healthy Weight Initiative, has drawn broad community support. They have partnered with IBFA and IPN to develop breastfeeding support strategies in keeping with their grant guidelines, and are using the Call to Action to Promote Breastfeeding in Indiana, developed by the IBFA in 2005, as a guide,.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The State Breastfeeding Consultant (SBC) will continue to build and support local coalitions around the state, serving as the liaison between the Indiana Breastfeeding Alliance (IBFA) and the local coalitions. She will also continue to identify issue				X
2. The SBC will continue to work collaboratively with Indiana Perinatal Network (IPN), IBFA, and local coalitions to provide expert advice to businesses and employees on the implementation of The Business Case for Breastfeeding for lactation support in				X
3. The two black breastfeeding coalitions will continue to strengthen their coalitions and expand their work in the African-American community to improve breastfeeding promotion and support and decrease the disparity in breastfeeding rates in the			X	X

Africa				
4. ISDH will roll out a new program to award hospitals a certificate if they are able to show that they meet the first five of the Ten Steps to Successful Breastfeeding, the basis of the Baby Friendly Hospital Initiative		X		X
5. ISDH, IPN, and IBFA will host an invitation-only one day forum for selected representatives of all the birthing hospitals in the state during which information will be presented about the Baby Friendly Hospital Initiative as well as the new Joint Com		X		
6. IBFA will continue to collaborate with the Indiana Healthy Weight Initiative, the IPN, WIC Purdue Extension and other partners to build in tiers of support for breastfeeding at all levels in the State Core Measure on exclusive breastfeeding				X
7. IBFA will continue to pursue insurance coverage for lactation consultation and supplies, and to create a registry of International Board Certified Lactation Consultants in the state				X
8.				
9.				
10.				

b. Current Activities
The founder of the first black breastfeeding coalition in Indiana participated in a CDC meeting in January 2010 to discuss the disparity in breastfeeding rates

The SBC secured grant funds to sponsor 15 people to take the exam to become an International Board Certified Lactation Consultant and included four African American and two bilingual candidates.

The SBC has continued actively working with local coalitions all over the state, increasing the number of coalitions to 40.

Indiana WIC won a large grant to improve their peer counselor program. They are using the funds to increase infrastructure and resources to support the program.

MCH and WIC staff have been meeting bi-monthly to form more collaborative relationships and become more knowledgeable about what the other is doing in the area of breastfeeding.

Indiana has three hospitals with the Baby Friendly designation and three more that have filed a Letter of Intent to Become Baby Friendly.

The ISDH DNPA continues working toward development of a state obesity prevention plan funded by a large grant from the CDC, in which one of the six target areas is to increase breastfeeding support.

The Indianapolis International Airport opened two lactation rooms in March 2010.

c. Plan for the Coming Year
Activities to impact this Performance Objective will include:

SBC will continue to build and support local coalitions around the state, serving as the liaison between the IBFA and the local coalitions. She will also continue to identify issues regarding breastfeeding around the state, problem-solve, and inform the IBFA of those that need action or

discussion.

SBC will continue to work collaboratively IPN, IBFA, and local coalitions to provide expert advice to businesses and employees on the implementation of The Business Case for Breastfeeding for lactation support in the workplace.

The two black breastfeeding coalitions will continue to strengthen their coalitions and expand their work in the African-American community to improve breastfeeding promotion and support and decrease the disparity in breastfeeding rates in the African American community.

ISDH will roll out a new program to award hospitals a certificate if they are able to show that they meet the first five of the Ten Steps to Successful Breastfeeding, the basis of the Baby Friendly Hospital Initiative. This is an initiative that, it is hoped, will help increase the number of Baby Friendly certified hospitals in Indiana.

ISDH and IPN, along with IBFA, will host an invitation-only one day forum for selected representatives of all the birthing hospitals in the state during which information will be presented about the Baby Friendly Hospital Initiative as well as the new Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

IBFA will continue to collaborate with the Indiana Healthy Weight Initiative, IPN, WIC Purdue Extension and other partners to build in tiers of support for breastfeeding at all levels in the State Core Measure on exclusive breastfeeding.

IBFA will continue to pursue insurance coverage for lactation consultation and supplies, and to create a registry of International Board Certified Lactation Consultants in the state.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98.4	98.6	99.6	99.7	98.5
Annual Indicator	99.6	97.8	98.1	99.5	99.5
Numerator	87371		88005	87076	
Denominator	87685		89719	87520	
Data Source				ISDH - UNHS	ISDH - UNHS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99.6	99.7	99.7	99.8	99.8

Notes - 2009

Source of data: ISDH UNHS

Notes - 2008
Program would not allow objective change for 2008; if it had, the projection would have been changed to 98.3 (and met), due to the final figures having been corrected for 2006 and 2007.

Source of data: ISDH UNHS

Notes - 2007
Source of data will be ISDH UNHS/EHDI Programs

a. Last Year's Accomplishments
As of January 1, 2010, 95 of 103 birthing facilities and 35 audiologists (~33% of all the pediatric audiologists in the state) used the Indiana State Department of Health (ISDH) EARS application.

The Early Hearing Detection and Intervention (EDHI) Program has consistently reported an average percentage of children lost to follow-up/documentation that is lower than the national average. Between 2005 -- 2009, a total of 504 Indiana newborns were identified with hearing loss.

A Memorandum of Understanding (MOU) to allow loaner hearing screening to be placed in facilities outside of ISDH has been finalized. ISDH should begin distributing this loaner equipment by mid-2010 .

In September of 2009, a new parent-to-parent mentoring program (Guide By Your Side) was initiated. Currently, 34 families have benefited from this new program.

EHDI participated in a learning collaborative through the National Institute on Child Health Care Quality (NICHQ) (funded by the Health Services and Resources Administration [HRSA]) to improve UNHS and EHDI follow-up.

EHDI staff worked with the Region IV Genetics Collaborative EHDI subcommittee to complete protocols for referring children for genetic counseling and genetic workup.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to work with individual hospitals to encourage timely and complete reporting of their children. EHDI has completed a transition to a web-based data management system (EARS).			X	
2. Continue to visit hospitals in their respective regions of the state to provide education and assist with issues related to screening, follow-up and reporting.				X
3. Continue to provide educational presentations to hospitals, public health nurses (PHN), students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and processes.				X
4. Continue efforts to educate physicians regarding follow-up results of referred children from UNHS.				X
5. Continue to work with public health nurses at local health departments to promote awareness of EHDI and the importance of follow-up.				X

6. Participate in training at least one midwife facility, which sees a large Amish population, in the next few months.				X
7. Continue to refine MCH reporting mechanisms through EARS and the Indiana Data System (IDS). The IDS allows sharing of information from Vital Records.			X	
8. Continue partnership with Indiana Hands & Voices to provide family education and support opportunities.		X		
9. ISDH Vital Records information will be shared with EARS, thereby providing EHDI staff with information from all children born within the state including those children born at home			X	
10. Continue to work with Level 1 centers and with centers interested in Level 1 status to maximize services for young infants and babies.			X	

b. Current Activities

Work with individual hospitals to encourage timely and complete reporting of their children and assist with issues related to screening, follow-up and reporting. All birthing hospitals have been trained and are currently using EARS.

Provide educational presentations to hospitals, public health nurses (PHN), students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and processes.

Educate physicians regarding follow-up results of referred children from UNHS.

Participate in training at least one midwife facility, which sees a large Amish population, in the next few months.

Refine MCH reporting mechanisms through EARS and the Indiana Data System (IDS).

Continue partnership with Indiana Hands & Voices to provide family education and support opportunities.

Share ISDH Vital Records information with EARS, providing EHDI staff with information from all children born within the state including those children born at home.

Work with Level 1 centers and with centers interested in Level 1 status to maximize services for young infants and babies.

Distribute "physician's toolkit" to providers of children who have been identified with a hearing loss through the EHDI program beginning April 2010.

Update the Indiana Family Resource Guide for Families with Children with Hearing Loss and translate into Spanish.

Participated in a NICHQ Learning Collaborative where goal was to improve access to care for children with hearing loss.

c. Plan for the Coming Year

EHDI will provide comprehensive performance data to individual birthing facilities, commendations and recommendations to improve rate of screening and referrals to the medical home, early intervention, and the EHDI program.

EHDI will assist at least two nurse/midwife facilities in obtaining screening equipment.

EHDI will continue to target midwifery facilities for implementation of UNHS.

EHDI will work with the Indiana University Laboratory (which receive heel stick cards for babies), to look at discrepancies between electronic reporting screening results via the heel stick card versus hospital screening program reporting in the EARS web-based data information system.

EHDI will provide two large trainings to audiologists on audiology procedures and related content areas to increase the skills, knowledge base and number of providers who serve very young babies and children.

Implemented spread of change tested in NICHQ learning collaborative throughout a single hospital system.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	8.7	9.5	8.5	7.5
Annual Indicator	9.5	10.0	7.0	8.0	7.5
Numerator	161260	158000	111000	126950	
Denominator	1689985	1577629	1584441	1584681	
Data Source				Kids Count Bk	Kids Count Bk
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.3	7	6.7	6.5	6.1

Notes - 2009
Program would not allow saving without indicator for 2009.

Notes - 2008
Source of data: Kids Count book (Ann Casey/Robert Wood Johnson Foundation); US Census Bureau.

Note: This is children age 17 and below.

Note: Numerator Calculated from actual denominator and indicator.

Notes - 2007
Source of data: Kids Count book (Ann Casey/Robert Wood Johnson Foundation); US Census Bureau.

Note: This is children age 17 and below.

a. Last Year's Accomplishments

Activities that impacted this Performance Objective included:

Indiana's Early Childhood Comprehensive Systems grant, the Sunny Start: Healthy Bodies, Healthy Minds initiative included strategies to increase the percentage of children on child care voucher programs who have health insurance. Twenty six financial fact sheets were developed for families including information on Medicaid and SCHIP.

The Sunny Start initiative provided service information to families via a website. The website was expanded to include more information. The Financial Fact Sheets, which included information on a variety of insurance related topics, were made available on the site, which received over 26,000 hits to the family resources section.

Maternal and Child Health (MCH) grantees served as enrollment sites for Hoosier Healthwise and referred clients to local Hoosier Healthwise enrollment sites.

The Indiana Family Helpline (IFHL) provided referrals and screened clients for Hoosier Healthwise eligibility.
MCH required all grantees providing primary care to children to be Medicaid providers.

A greater emphasis was placed on MCH Family Care Coordination grantees that facilitated children into Hoosier Healthwise.

The MCH Director served on the Board of Covering Kids & Families, which advocates for health coverage for Indiana families and participated on the Hospital & Health Center subcommittee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCHB funded project, the Indiana Early Childhood Comprehensive Systems initiative includes strategies to increase the percentage of children on child care voucher programs who have health insurance.		X		
2. The MCH Sunny Start: Healthy Bodies, Healthy Minds initiative provides service information to families via a website. The website will be expanded to include more information.				X
3. MCH grantees serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.				X
4. The Indiana Family Helpline provides referrals and screens clients for Hoosier Healthwise eligibility.		X		
5. MCH requires all grantees providing primary care to children to be Medicaid providers.		X		
6. MCH Family Care Coordination grantees facilitate children into Hoosier Healthwise. Emphasis on doing so will be increased.		X		
7. The MCH Director serves on the Board of Covering Kids & Families, which advocates for health coverage for Indiana families and participate on the Health Policy subcommittee.				X
8. The IN CISS Project is providing training within 12 Medical Home Learning Collaborative practices to families, practice staff and physicians on healthcare financing options for CYSHCN and their families.			X	
9.				
10.				

b. Current Activities
The MCH Sunny Start: Healthy Bodies, Healthy Minds initiative is providing service information to families via a website. The website is being completely redesigned and expanded to include more information. The Financial Fact sheets are updated and new topics will be added, as appropriate.

MCH grantees serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.

The IFHL provides referrals and screen clients for Hoosier Healthwise eligibility.

MCH requires all grantees providing primary care to children to be Medicaid providers.

MCH Family Care Coordination grantees facilitate enrolling children into Hoosier Healthwise.

MCH staff is working with Covering Kids & Families (CKF) , which advocates for health coverage for Indiana families and participates on the Health Policy Subcommittee. The Executive Director of Covering Kids now serves as the Chairman of the Sunny Start Evaluation Committee and provides regular updates to the Committee as well as at the quarterly Sunny Start Core Partners meetings regarding the current insurance enrollment trend data of Hoosier children.

The Indiana Community Integrated Systems of Services Project (IN CISS) developed a strategic plan with Medicaid and Managed Care Organizations to develop 12 pilot demonstrations of a Medical Home financial model in Indiana that demonstrates the value (quality/cost) of Medical Home as the model of primary care.

c. Plan for the Coming Year
The MCH Sunny Start: Healthy Bodies, Healthy Minds initiative will be updated to include more information and ensure that the information is current. The Financial Fact sheets will be kept updated and new topics will be added as appropriate.

MCH grantees serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.

The IFHL will provide referrals and screen clients for Hoosier Healthwise eligibility.

MCH will require all grantees providing primary care to children to be Medicaid providers.

MCH Family Care Coordination grantees will facilitate children into Hoosier Healthwise.

MCH staff will work with CKF and continue to participate on the Health Policy Subcommittee. The Executive Director of CKF will serve as the Chairman of the Sunny Start Evaluation Committee and will provide regular updates to the Committee as well as at the quarterly Sunny Start Core Partners meetings regarding the latest insurance enrollment trend data of Hoosier children.

IN CISS will continue working on the strategic plan with Medicaid and Managed Care Organizations to support the 12 pilot demonstrations of a Medical Home financial model in Indiana that demonstrates the value (quality/cost) of Medical Home as the model of primary care.

IN CISS will continue to provide training within the 12 Medical Home Learning Collaborative practices to families, practice staff and physicians on healthcare financing options for Children and Youth with Special Health Care Needs (CYSHCN).

Sunny Start and the IN CISS grant project staff will continue collaborating to increase information

to families.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		23	49	17	30
Annual Indicator	23.0	17.5	29.8	30.8	36.5
Numerator	18232	14862	20391	24218	21292
Denominator	79406	84925	68500	78700	58260
Data Source				ISDH - WIC pgm	ISDH - WIC pgm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	36.5	36.5	36	35.5	35

Notes - 2009
Note: Denominator calculated depending on the rate and numerator.

Notes - 2008
Date for 2005 and 2006 was incorrectly reported. The corrected figures would be 28% and 28.2% respectively. This also would have made the objective in 2007 28% and in 2008 27.8%. Application would not allow change of 2007 or 2008 objectives. Source of data: ISDH WIC program.

Notes - 2007
Date for 2005 and 2006 was incorrectly reported. The corrected figures would be 28% and 28.2% respectively. This also would have made the objective in 2007 28% and in 2008 27.8%. Application would not allow change of 2007 or 2008 objectives. Source of data: ISDH WIC program.

a. Last Year's Accomplishments
Activities to impact this Performance Objective included:

WIC health professionals screened all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals also screened all children for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI 85% to < 95%) status using height for weight BMI.

WIC health professionals assessed WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCH clinics also assessed children's diets for nutrition and eating habits that would impact growth patterns.

When appropriate, WIC staff provided counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. When appropriate, MCH clinics

provided guidelines on healthy eating habits and physical activity to families and children.

WIC displayed posters/bulletin boards on physical activity, nutrition and healthy eating. MCH clinics displayed posters and created bulletin boards communicating information on physical activity, nutrition and healthy eating habits.

WIC provided educational materials (books, handouts, videos) on healthy eating and physical activity. MCH clinics provided educational information (handouts/fliers) on healthy eating and physical activity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCH health care professionals are also screening all participants for "Overweight	X			
2. WIC health professionals are assessing WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCH clinics assess children's diets for nutrition and eating habits that would impact growth patterns.	X			
3. When appropriate, WIC provides counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCH clinics provide guidelines on healthy eating habits and physical activity		X		
4. WIC is displaying posters/bulletin boards on physical activity, nutrition and healthy eating. MCH clinics is displaying posters and creating bulletin boards communicating information on physical activity, nutrition and healthy eating habits.		X		
5. WIC provides educational materials (books, handouts, videos) on healthy eating and physical activity. MCH clinics are providing educational information (handouts/fliers) on healthy eating and physical activity		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Activities to impact this Performance Objective include:

WIC health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCH health care professionals are also screening all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI85% to < 95%) status using height for weight BMI.

WIC health professionals are assessing WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCH clinics are assessing children's diets for nutrition and eating habits that would impact growth patterns.

When appropriate WIC are providing counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCH clinics are providing guidelines on healthy eating habits and physical activity to families and children.

WIC is displaying posters/bulletin boards on physical activity, nutrition and healthy eating. MCH clinics is displaying posters and creating bulletin boards communicating information on physical activity, nutrition and healthy eating habits.

WIC are providing educational materials (books, handouts, videos) on healthy eating and physical activity. MCH clinics are providing educational information (handouts/fliers) on healthy eating and physical activity.

c. Plan for the Coming Year
Activities to impact this Performance Objective include:

WIC health professionals will screen all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCH health care professionals will also screen all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI85% to < 95%) status using height for weight BMI.

WIC health professionals will assess WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCH clinics will assess children's diets for nutrition and eating habits that would impact growth patterns.

When appropriate WIC will provide counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCH clinics will provide information on healthy eating habits and physical activity. MCH clinics will also provide information on family activities that support healthy eating/physical activity habits.

WIC will provide educational materials (books, handouts, videos) on healthy eating and physical activity. MCH clinics will provide educational and referral information on healthy eating habits, physical activity and family- and community-centered activities that support healthy nutrition and physical activity.

MCH will support DNPA initiatives, objectives and strategies in the reduction of percentage of children, ages 2 to 5 years, with a Body Mass Index at or above the 85th percentile.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		16.1	15.8	15.6	15.6
Annual Indicator	16.2	15.9	17.3	18.5	17.5
Numerator		15589	17005	16232	
Denominator		97788	98408	87827	
Data Source				ISDH - VR	ISDH - VR
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.5	17	16.5	16	15.5

Notes - 2009
Source of data: ISDH Vital Records (Birth Certificate Information)

Notes - 2008
Percentage provided by ISDH VR

Source of data: ISDH Vital Records (Birth Certificate Information)

Notes - 2007
Percentage and numerator provided by ISDH VR; denominator calculated.

Source of data: ISDH Vital Records (Birth Certificate Information)

a. Last Year's Accomplishments
Activities that impacted this Performance Objective include:

MCH continued to facilitate the legislated Prenatal Substance Abuse Commission (PSAC). Meetings were held bi-monthly. A Final report with recommendations was submitted to the legislature in July, 2009. Recommendations include continuing the PSAC commission; conducting a baseline meconium study at a representative sample of hospitals to identify type and prevalence of current substance use with repeat study in three to five years; training all perinatal health care providers on screening, brief intervention, and referral; hiring a state PSAC coordinator to create an informational website, keep county resources and trainings updated, provide technical assistance to counties. The legislators assigned to the commission will present a bill to fund the recommendations with collection of non-cigarette tobacco products.

The ISDH Prenatal Substance Use Prevention Program (PSUPP) identified 4,850 high risk, chemically dependent pregnant women and provided counseling and intervention. They also began collaborating with Indiana Access to Recovery, a program to assist substance users in getting the professional help they need to quit. This program targets pregnant women as one of their target groups.

PSUPP/MCH continued their collaboration with ITPC to have greater impact on smoking cessation with pregnant women. The Indiana Tobacco Quit Line has expanded its follow-up, call-back protocol of smoking mothers once they deliver.

PSUPP and all MCH-funded prenatal clinics incorporate education of women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

MCH staff collaborated with Hoosier Healthwise & Contracted MCO's health care providers and outreach workers on smoking cessation. A training of physician representatives of all 3 MCO's on evidence based assessment tools, the 5A's, 5R's and the Indiana Tobacco Quitline was provided by the Coalition to Prevent Smoking in Pregnancy (CPSP) of which MCH is a member.

All ITPC County Coalitions have been trained in the prenatal office training model and are replicating the in office training in 80 counties.

MCH collaborated with Indiana ACOG to disseminate information on prenatal smoking cessation and one IPN Newsletter was dedicated to prenatal smoking.

MCH consultant will continue to provide brochures on "You and Me Smoke-Free" and the "ASK" Protocol as well as offer downloading from the IPN website.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Target counties with the highest smoking rates among the Medicaid population, for outreach and training initiatives.			X	
2. Collaborate with the Prenatal Substance Use Prevention Program (PSUPP) to have PSUPP Coordinators at the county level provide brief intervention trainings to our Title V funded projects in their county. Also have them available to provide technical		X		
3. Partner with Indiana Tobacco Prevention Coalition (ITPC) to assist with enhanced training for Title V projects on how to assist the woman in quitting and how to appropriately follow-up on all smokers.		X		X
4. Create and disseminate prenatal smoking data briefs based on age, race/ethnicity, insurer, and geographical location of the targeted population.			X	
5. Collaborate with agency partners to assist with dissemination of appropriately targeted smoking cessation messages to populations of women of childbearing age and pregnant women on Medicaid. Include smoking messages in each agencies literature. Par			X	
6. Work with ITPC and CPSP to explore successful culturally, literacy appropriate educational messages targeted to low income women of childbearing age and pregnant women.		X		
7. Monitor use of reimbursable tobacco screening and cessation counseling codes by prenatal care providers before and after trainings completed. Recommend initiatives/incentives to encourage physicians and other health care providers to take a more act		X		X
8. Continue to promote Text4baby as another way to reach pregnant women and new mothers with smoking messages.			X	
9.				
10.				

b. Current Activities

ISDH will continue with the PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan. (The legislature refused to reauthorize the commission and plans are currently on hold.)

MCH will continue to collaborate with the ITPC/CPSP to focus on training for prenatal care providers and the Medicaid population. (5 regional trainings have been held so far this grant year. CPSP is also coordinating trainings with AHEC trainings.)

All MCH Title V funded prenatal services are mandated to address Federal Performance Measure 15. mandated activities include: 1) 100% of clients will be asked if they smoke or are exposed to

second hand smoke at time of enrollment and smoking status documented in chart, 2) All clients who state they are smoking at time of enrollment will be assessed using the stages of change model* and documented in chart, 3) All clients who state they are smoking at time of enrollment will be monitored at each visit for smoking status, 4) 100% of pregnant women will receive information on the hazards of smoking during pregnancy, 5) All patients smoking at time of enrollment will be enrolled in a cessation/treatment program or referred to a program if not available on site. In addition, all projects are to have at least one trained staff member who can teach other staff how to screen for smoking, utilize the stages of change model, and provide brief intervention.

c. Plan for the Coming Year

Smoking rates are not going down as we had hoped. Indiana currently ranks 49th in the country for percent of women smoking. According to the 2009 Revised Birth Certificate 17% of all pregnant women continue to smoke.

Proposed Activities Include:

Target counties with the highest smoking rates among the Medicaid population, for outreach and training initiatives.

Collaborate with the Prenatal Substance Use Prevention Program (PSUPP) to have PSUPP Coordinators at the county level provide brief intervention trainings to our Title V funded projects in their county. Also have them available to provide technical assistance if needed.

Partner with Indiana Tobacco Prevention Coalition (ITPC) to assist with enhanced training for Title V projects on how to assist the woman in quitting and how to appropriately follow-up on all smokers.

Create and disseminate prenatal smoking data briefs based on age, race/ethnicity, insurer, and geographical location of the targeted population

Use data briefs and Quitline materials to educate health care providers, local health department staff, community policy leaders, and consumers about the prevalence of smoking during pregnancy, including the consequences of smoking before, during and after pregnancy, best practice models for awareness activities to target low income women, and proposed best practice models to decrease smoking among women of childbearing age across the lifespan with special emphasis on the Indiana Tobacco Quitline

Collaborate with agency partners to assist with dissemination of appropriately targeted smoking cessation messages to populations of women of childbearing age and pregnant women on Medicaid. Include smoking messages in each agencies literature. Partners will include ITPC, Clarian Health Women's Center of Excellence, MOD, American Lung Association, IPN, Indiana Latino Institute, Office of Women's Health, WIC, Office of Nutrition and Physical Activity, Chronic Disease, Asthma, Diabetes, Hypertension, HIV/STD, Family Planning, Breast and Cervical Caner, Vital Records, Marion County Health and Hospital, Local health departments, MCH clinics, CHCs, FQHCS, Dentists, PSUPP clinics.

Work with ITPC and CPSP to explore successful culturally, literacy appropriate educational messages targeted to low income women of childbearing age and pregnant women.

MCH Consultant will attend all meetings of Medicaid Neonatal Quality Outcomes committee to work on prenatal smoking cessation among the Medicaid population

Monitor use of reimbursable tobacco screening and cessation counseling codes by prenatal care providers before and after trainings completed. Recommend initiatives/incentives to encourage

physicians and other health care providers to take a more active role with their pregnant patients that smoke

Continue to promote Text4baby as another way to reach pregnant women and new mothers with smoking messages.

Baby First Packets will be sent to Prenatal Indiana Family Help Line callers.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	8	6.9	7.1	6.9
Annual Indicator	6.9	7.3	8.0	9.5	8
Numerator	31	33	36	43	
Denominator	450445	450758	452551	451711	
Data Source				ISDH - ERC	ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9	9	8.8	8.6	8.5

Notes - 2009
Projection from data provided by ERC.

Source of data: ISDH - ERC

Despite Data Alert, the application does not allow changing of 2009's objectives, which would eliminate the data alert. Perhaps this can be discussed as a change in TVIS for next year.

Notes - 2008
Numerator calulated depending on the Denominator and the rate.

Source of data: ISDH - ERC

Notes - 2007
Fluctuating rate; Data from 2007 and previous years is now final.
.

Source of data: US Census Bureau, ISDH ERC

a. Last Year's Accomplishments
State Adolescent Health Coordinator (SAHC) facilitated the Indiana Coalition to Improve Adolescent Health (ICIAH). The coalition released the state's first adolescent health plan in May

2009. The reduction of suicidality and the increase in mental health services for adolescents are two priorities found in the plan.

SAHC was the consultant for a school-based adolescent health clinic who implemented the Natuaral Helpers program throughout the county high schools. Natural Helpers is a peer-led suicide prevention program.

The Indiana Suicide Prevention Coalition (ISPC) organized members and local suicide prevention councils/coalitions to implement statewide awareness activities for National Suicide Prevention Week. Nine "Out of Darkness" and four suicide prevention walks were held throughout the state. Editorials and press releases were submitted to newspapers in the state during this week.

ISPC provided technical assistance to 115 individuals and organizations regarding suicide prevention, intervention and postvention. Ongoing technical assistance is provided to existing suicide prevention councils/coalitions.

ISPC encouraged the development of new regional/local suicide prevention councils. ISPC met with individuals in underserved areas of the state to provide technical assistance related to forming a new council.

ISPC disseminated information on evidence-based suicide prevention/intervention training and programs at 11 conferences/events and to community health centers, schools and colleges, employers, correctional facilities, senior community providers, health care providers, and clergy.

ISPC provided suicide prevention training (QPR, safeTALK, ASIST) to interested organizations and groups including five trainings to guidance counselors through the Indiana Department of Education Counselor Regional Workshops.

ISPC finalized the updated Indiana Department of Education "Student Suicide" manual and collaborated with the Indiana Department of Education to design and pilot workshop to disseminate the new "Student Suicide" Manual. The manual will be reviewed by the DOE in winter 2010.

ISPC partnered with Indiana Partnership to Prevent Violent Injury and Death to distribute Harvard University's "Means Matter" Report to targeted audiences, distribute information on "Counseling on Access to Lethal Means" (CALM) training to targeted audiences.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner with organizations through the Indiana Coliation to Improve Adolescent Health (ICIAH) to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.				X
2. Support the implementation of the Natural Helpers Program, a suicide prevention program, by funded school-based clinics.	X	X		
3. Support the activities of the Indiana Suicide Prevention Coalitions (ISPC) in hosting ASIST trainings and safeTALK trainings throughout the state.			X	X
4. Build partnerships with the Division of Mental Health and Addiction to address suicide prevention activities.				X
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
ISDH is writing an updated suicide data report to include 2006-2007 mortality and hospital discharge data.

SAHC is partnering with the Division of Mental Health and Addiction to assist with the planning of a suicide prevention summit to be held in 2010.

SAHC is continuing to partner with organizations through ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.

SAHC is continuing to support the implementation of the Natural Helpers Program by school-based clinics.

ISPC is partnering with Indiana Partnership to Prevent Violent Injury and Death to distribute Harvard University's "Means Matter" Report to targeted audiences, distribute information on "Counseling on Access to Lethal Means" (CALM) training to targeted audiences.

ISPC will hold ASIST trainings and safeTALK Training for Trainers for Community Health Centers around the state.

ISPC will hold bi-monthly meetings for members to share information and resources.

c. Plan for the Coming Year
SAHC will partner with organizations through ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.

SAHC will support the implementation of the Natural Helpers Program by school-based clinics.

ISDH and SAHC will supporting the work and efforts of the ISPC.

ISDH will administering and ensure the collection of weighted data for the Youth Risk Behavior Survey (YRBS) for 2011. YRBS provides data on risk behaviors for adolescents and teens including important information regarding the percentage of high school students who have planned a suicide or attempted a suicide, and students' feelings of sadness and hopelessness during the past year.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	77	80	81	78	80
Annual Indicator	77.4	70.3	56.3	79	78
Numerator	947	893	738		
Denominator	1224	1271	1310		

Data Source				MCH Cons Pgm	MCH Cons Pgm
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	72	72	72	72

Notes - 2009
See general form note for Form 11 for detailed explanation.

All data are for the calendar year and not the fiscal year.

Estimates provided based on trend anaysis. CY2009 data is not yet available.

Source of data: ISDH MCH Consultant Program.

Despite Data Alert, the application does not allow changing of 2009's objectives, which would eliminate the data alert. Perhaps this can be discussed as a change in TVIS for next year.

Notes - 2008
All data are for the calendar year and not the fiscal year.

Estimates provided based on trend anaysis. CY2008 data is not yet available.

Source of data: ISDH MCH Consultant Program.

Notes - 2007
There is no official designation for level-three hospitals in Indiana; they are self-reported. This means the number of hospitals and the number of births in them appropriate to this measure can and does vary. In 2007 this figure was significantly lower than in 2006. Because this may be an outlier, the projection for 2008 and the associated objectives remain unchanged.

All data are for the calendar year and not the fiscal year.
Source of data: ISDH MCH Consultant Program.

a. Last Year's Accomplishments
The Indiana Hospital Levels of Care document was updated and disseminated through the State Perinatal Advisory Board meetings, the Perinatal Newsletter, Indiana Perinatal Network (IPN) website, and at various conferences throughout the FY. There is an overall increase in NICUs in Indiana since the previous survey of hospitals in 2005. Results of the self-reported survey completed 9/30/08 show that there are now two Level IIIC NICUs, 17 Level IIIB NICUs, and two Level IIIA NICUs.

The Indiana Prenatal Care Guidelines were updated by IPN in collaboration with MCH, INACOG, and INAAP. The guidelines were completed 9/30/08 and disseminated throughout FY 2009. The guidelines can be found on the IPN website at indianaperinatal.org

MCH continued to attend monthly meetings of the Office of Medicaid Policy and Planning (OMPP) Quality Strategy Prenatal Workgroup.

MCH completed an in-depth analysis of prematurity and low birthweight in Indiana looking at all maternal factors, incidence of inductions and cesareans by hospital, level of care, county, day/time.

Further assessment of the "Hospital Level and Delivery Volume and Neonatal Mortality among Very Low Birth Weight Infants" report showed that VLBW infants born at level I hospitals were more likely to be less than 500 grams and less than 24 weeks of gestation and were less likely to be a multiple birth or cesarean delivery than those born at level III hospitals. The strongest predictor of delivery outside level III hospitals was the mother's county of residency, usually rural and not in close proximity to a Level III hospital resulted in the highest neonatal mortality rate. Results of this study suggest that increased use of hospitals with level III neonatal care might reduce neonatal mortality among VLBW infants. Indiana needs to boost its efforts in increasing the delivery of VLBW infants in subspecialty hospitals. These results were used in setting up the PCEP Train--The-Trainer initiative.

In FY 2009, The Title V funded IPN Perinatal Continuing Education Program (PCEP) coordinator developed an updated training curriculum using PCEP and new educational tools and curriculum and piloted a training partnership between St. Vincent's Woman's Hospital a Level IIIB hospital in Indianapolis Reid Memorial Hospital in Richmond, a Level II hospital, and Fayette Memorial Hospital in Connersville, a Level II hospital. The training was successful and will be replicated in 2010.

MCH and IPN began to work with Lake County Methodist Hospital North, to assess competency levels, provide TA on how to do an equipment inventory, and how to build a perinatal network. This was effort was sidelined due to loss of the Lake County Methodist Hospital North Perinatal Manager that was spearheading this effort and a decrease in funding for the IPN PCEP coordinator.

MCH worked closely with the Office of Medicaid Policy and Planning to share birth data by race and county. The finalized 2007 linked Medicaid singleton birth data was released March, 09 and shared with MCOs, and IPN and March of Dimes.

IPN was successful in efforts to expand the state perinatal network membership with new members from Allen County, Marion, and Delaware Counties.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Establish a Perinatal Level of Hospital Care Task Force.				X
2. Use state and local data on VLBW to identify program priorities and policies to address VLBW in Indiana.				X
3. Obtain an MOU with one Level III hospital in the third quarter to develop an updated training curriculum using PCEP and new educational tools and curriculum, and host coordinator workshops with staff from 2 Level II or I hospitals.		X		
4. Begin assessment of the perinatal system in Indiana.				X
5. Create standard definitions and guidelines for each hospital level of care.				X
6. Training of prenatal care providers on universal screening for alcohol, tobacco and other drugs and brief interventions will be completed in two counties by the fourth quarter.		X		

7. MCH will continue to work closely with the Office of Medicaid Policy and Planning (OMPP) to share data and implement initiatives to decrease neonatal mortality.				X
8.				
9.				
10.				

b. Current Activities
Current activities include:

Convening a task force of perinatal experts to assess the current state of the perinatal system in Indiana, research best practice models of perinatal care, make recommendations for improving perinatal in Indiana.

Using state and local data on VLBW to identify program priorities and policies to address VLBW in Indiana. Monitor birth certificate and local data and disseminate a yearly report to the State Perinatal Advisory Board, providers and county health officers on VLBW outcomes by hospital level of care, by race and county

Obtaining an MOU with one Level III hospital in the third quarter to develop an updated training curriculum using PCEP.

State Perinatal Advisory Board met in February 2010 to discuss hospital levels of care. MCH is establishing a task force to begin assessment of the perinatal system in Indiana, create standard definitions and guidelines for each hospital level of care.

Training of prenatal care providers on universal screening for alcohol, tobacco and other drugs and brief interventions will be completed in two counties by the fourth quarter.

Working closely with the Office of Medicaid Policy and Planning to share data and implement initiatives to decrease neonatal mortality.

c. Plan for the Coming Year
Planned activities for the coming year include:

Over the next five years Indiana will take a new focus to ensure that very low birthweight infants are born in appropriate level hospitals. MCH will establish a Perinatal Level of Hospital Care Task Force to ensure appropriate perinatal deliveries of high risk mothers and neonates, write and publish code, regulations, standards, guidelines for all three levels of hospital care for OB and NICU care, including development of a system of transport of high-risk mothers prior to delivery.

Convene a Clinical Advisory Group (CAG) made up of Neonatologists and Maternal Fetal Medicine specialists to assist ISDH with writing Administrative Code on Levels of Hospital Care that will be tied in with hospital licensure. The CAG will be charged with assisting ISDH in research of other states have administrative code around levels of OB and Newborn care to guide Indiana's efforts to develop perinatal regulations and standards, including possible hospital licensure regulations governing maternal and newborn services to ensure women and infants receive the most appropriate care for their medical needs and to reflect current state of practice at level I, II and level III hospitals.

MCH will continue to facilitate and expand the Perinatal Task Force to include representatives from all stakeholders to complete tasks such as development of a new survey to assess level of

hospital care, educational materials for providers and consumers, design and implement a statewide conference on very low birthweight issues.

MCH will work with the CAG to assess and develop a system of data collection for an updated report of causes of very low birthweight infants, and hospital level of care where infants were born.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81.1	81	78.5	76.6	77.5
Annual Indicator	78.2	77.6	67.5	66.7	68.5
Numerator	68723	69358	60535	58390	
Denominator	87864	89404	89719	87520	
Data Source				ISDH - ERC	ISDH - ERC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	66	68	70	72	74

Notes - 2009
Projected figure based on actual previous years and 2008 data from ISDH - ERC.

Source of data: ISDH ERC

Despite Data Alert, the application does not allow changing of 2009's objectives, which would eliminate the data alert. Perhaps this can be discussed as a change in TVIS for next year.

Notes - 2008
Source of data: ISDH ERC

Notes - 2007
Program will not allow us to change objective for 2007 or it would have been lowered due to a change in the questions asked and reocding of information on the Electronic Birth Certificate which was modified in 2007. Objectives for 2007 through 2009 would have been significantly lowered had the program allowed us to change them. Future objectives, from 2010 through 2014, have been mofied in accordance with current and past years' experience since the 2007 change.

Source of data: ISDH ERC

a. Last Year's Accomplishments
MCH continued to disseminate the Baby First educational materials statewide through the Indiana Family Helpline. Fifteen Baby First educational packets at a time were distributed to prenatal

care providers, and agencies and one packet was sent to each individual that requested one of packets from the Indiana Family Helpline.

MCH formed a Prenatal Care Coordination Task Force to review the current state program and restructure the prenatal care coordination (PNCC) program to fit into new CMS and local Medicaid rules and programs. Updated standards, redefined services, new forms and data gathering tools were developed. Operational guidelines for working with Medicaid and the managed care organizations (MCOs) have been developed.

County data books, including entrance into prenatal care continue were updated as new data was available on the ISDH website and shared with local communities in counties with significant access problems. 2006 data is all that is currently available. The website will be updated with 2007 data when it becomes available.

Funding of prenatal care coordination projects throughout the state provided outreach, case finding, referral, advocacy, and education of at risk pregnant women. MCH continues to fund 15 PNCC projects with Title V.

Title V funded prenatal care and PNCC projects continue to be mandated in 2010 to provide neighborhood outreach through the MCH free pregnancy program, enroll women with positive pregnancy tests, identify another project specific outreach activity, and identify another project activity to increase enrollment in the first trimester. Projects reported results quarterly.

Vital Records data on trimester of entrance into prenatal care was shared with the State Perinatal Advisory Board, was published in a Perinatal Perspectives Newsletter and was shared with counties with access to care problems will receive technical assistance from MCH to identify barriers and plans to improve access. Data shows that entrance into prenatal care is decreasing across the state and for all races. The Perinatal Advisory Board will begin to look at assessment of decreasing available OB providers and hospital closings.

IPN hosted a third "Controversies and Innovations in Perinatal Health", State Perinatal Forum March 18-19, 2009 with a focus on access to care. A panel of physicians and hospital administrators looked at the accessibility of prenatal care in rural and non urban counties. Model programs were presented in break out sessions.

Aimed to implement the Early Start program in at least one of the counties with poor access to prenatal care due to systems barriers. MCH had several meeting with Elkhart County Health Department but an Early Start clinic was not started due to lack of available funds.

After several meetings, MCH, IPN, Title X and the Office of Medicaid Policy & Planning (OMPP) decided to reinstate the plan for presumptive eligibility (PE). MCH worked closely with OMPP on this and PE went into effect statewide July 1, 2009. In addition MCH worked with OMPP and MCOs to develop a Notification of Pregnancy (NOP) form. Data collected on this form includes history, current pregnancy, health risks, BMI, substance use, psychosocial status indicators, and more. The NOP is completed by the physician on all Medicaid eligible women at the time of the first prenatal visit. OMPP shares NOP data with MCH. In the first two and a half months of the programs (7-1-09 -- 9-30-09) 2,764 Notification of Pregnancy forms were completed. 38% of the women were in the first trimester at first prenatal care visit.

Target one emergency department in one Priority County to implement the ER protocol to refer all pregnant women in the ER to PNCC and a MCH funded prenatal clinic or CHC. Lake County MCH Network in collaboration with Methodist Hospital, Gary has developed a referral form, protocol and resource guide for ER staff seeing pregnant women.

MCH is partnered with Indiana March of Dimes, Indiana Perinatal Network, Anthem Healthcare, the Women's Center of Excellence, Purdue University/ISDH Multi-state Learning Collaborative

and others to prepare for a Perinatal Initiative summit to develop a state plan to address low birthweight and prematurity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V funded prenatal and PNCC projects are mandated in 2010 to provide neighborhood outreach through the MCH free pregnancy program, enroll women in services at time of positive pregnancy tests, and identify another project activity to increase en	X			
2. MCH will explore incorporating community based Doulas into Healthy Families Indiana and PNCC to facilitate early identification of repeat pregnancies and assistance and follow-up of mothers through the pregnancy.				X
3. ISDH Maternal Child Health Services, Office of Minority Health, and Office of Public Affairs are partnering to create a media campaign targeted to Black women in Allen, Lake, Marion, and St. Joseph Counties. Messages will encourage Black women of ch			X	
4. MCH is promoting the Text 4 baby program through all Title V funded projects, community health centers, county health officer conference call, putting information on MCH website, and IPN website.				X
5. MCH will also present information about the Text 4 baby program at Indiana Black Expo in July.				X
6. Counties with the lowest first trimester entrance into prenatal care, and counties with the highest first trimester entrance into prenatal care will be assessed for barriers and success and results will be published in a state report.				X
7. MCH continues to disseminate the Baby First educational materials statewide through the Indiana Family Helpline (IFHL).			X	
8.				
9.				
10.				

b. Current Activities

Title V funded prenatal and PNCC projects are mandated in 2010 to provide neighborhood outreach through the MCH free pregnancy program, enroll women in services at time of positive pregnancy tests, and identify another project activity to increase enrollment in the first trimester.

MCH is exploring incorporating community based doulas into Healthy Families Indiana and PNCC to facilitate early identification of repeat pregnancies and assistance and follow-up of mothers through the pregnancy.

MCH, Office of Minority Health, and Office of Public Affairs are partnering to create a media campaign targeted to Black women in Allen, Lake, Marion, and St. Joseph Counties. Messages will encourage Black women of childbearing age to take care of themselves, stop smoking, eat right, and if pregnant see a doctor early.

MCH is promoting the Text 4 baby program through all Title V funded projects, community health centers, county health officer conference call, putting information on MCH website, and IPN

website. MCH will also present information about the Text 4 baby program at Indiana Black Expo in July.

Counties with the lowest first trimester entrance into prenatal care, and counties with the highest first trimester entrance into prenatal care will be assessed for barriers and success. Information obtained will be shared at the next State Perinatal Advisory Board meeting.

c. Plan for the Coming Year
MCH will address systems, provider, individual barriers to accessing care, as well as local capacity to provide quality care, and disparities in access to early and ongoing prenatal care, and outcomes of maternity care in 2011. MCH consultant will work with, IPN members, local health department, and other local partners to identify counties with the highest first trimester entrance into prenatal care and meet with/survey county stakeholders to identify lessons learned and best practice models. MCH consultant, working in collaboration, will identify counties with the lowest first trimester entrance into prenatal care and meet with/survey county stakeholders to identify lessons learned and best practice models.

A MCH consultant will monitor birth certificate data and disseminate a yearly report to the State Perinatal Advisory Board, providers and county health officers on Natality outcomes by race and county. MCH consultant will use GIS techniques to target areas in the state where access to prenatal care occurs late or not at all and areas where poor birth outcomes exist. A Report of findings will be shared.

Women may enter the emergency room for a health complaint and find out she is pregnant. Often there is no coordination of care or referral follow-up to ascertain if the pregnant woman got into prenatal care. MCH will implement the IPN consensus ER protocol in one ER in one Priority County with an existing MCH program in 2011 to improve access to prenatal care in the first trimester.

MCH will work on increasing the percent of women enrolling in presumptive eligibility (PE) at MCH funded prenatal care clinics, prenatal care coordination programs, community health centers and local health departments.

MCH consultant will continue to work with OMPP, Managed Care Organizations and Indiana Perinatal Network (IPN) to restructure and build a comprehensive, collaborative system of providing case management services to all high risk mothers on Medicaid.

MCH will partner with the ISDH Office of Minority Health to develop and implement media messages targeted to high risk black women of childbearing age in the five disparity counties (Allen, Lake, Marion, St. Joseph, Vanderburgh).

D. State Performance Measures

State Performance Measure 1: *The number of data sets, including the NBS, UNHS, Lead, IBDPR, Immunizations, CSHCS, Vital Statistics, and First Steps Data, that are completely integrated into the Indiana Child Health Data Set.*

a. Last Year's Accomplishments
The integration of the EHDI (Early Hearing Detection and Intervention) portion of Newborn Screening, and the Indiana Birth Defects and Problems Registry into the Indiana Child Health

Data Set for initial use was completed.

The integration work and testing of First Steps data continued.

The use of verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations continued.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This performance measure is being retired because its objectives have been met.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Newborn Heel Stick Screening data mart development and implementation is continuing.

The Lead program integration/linkage evaluation along with the CHIRP data evaluation for integration/linkage is continuing.

The Children's Special Health Care Services and The First Steps data is being intergrated into the Indiana Child Health Data Set.

This State Performance Measure is being retired because this measure has been met as to the extent it can be by MCH.

c. Plan for the Coming Year
This State Performance Measure is being retired. The objectives have been met.

State Performance Measure 2: *The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0 - 493.9) among children less than five years old.*

a. Last Year's Accomplishments
In April 2009, the Asthma Program (along with the Indiana Joint Asthma Coalition) launched statewide asthma training for child care providers. Asthma training was provided free of charge to any child care provider in the state requesting the training. Training was delivered by the Child Care Health Consultants within the Bureau of Child Care, Family and Social Services Administration. Participants received a folder of materials to reinforce training messages, a poster with steps to take during an asthma emergency, and a cleaning spray bottle with messages on how cleaning can remove asthma triggers.

The Asthma Program worked with the Indiana Tobacco and Prevention and Cessation Head Start Advisory Group on a toolkit to help Head Start centers address children's exposure to

environmental tobacco smoke (ETS) and reduce smoking among staff and parents.

The Asthma Program received an award from the American Academy of Pediatrics, to support a visiting lecturer for two days to address secondhand smoke and children's health. On May 20th and 21st, Dr. Jonathan P. Winickoff presented to pediatricians, health leaders and local tobacco coalitions to share methods for reducing children's exposure to secondhand smoke.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Asthma Program promotes asthma training for child care providers. The Asthma Program distributes follow-up materials to participants.		X		
2. The Asthma Program and InJAC are developing an online asthma training for child care providers to complement existing in-person trainings.		X		
3. Data from the Children's Call-Back Survey of the Behavioral Risk Factor Surveillance System is being obtained. This is the first time Indiana is able to provide detailed information on asthma among children.				X
4. In Fall 2009, the Asthma Program and InJAC launched a continuing medical education (CME) online training for health care providers.		X		
5. The Asthma Program is promoting the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Asthma Program promotes asthma training for child care providers. The Asthma Program distributes follow-up materials to participants.

The Asthma Program and InJAC developed an online asthma training for child care providers to complement existing in-person trainings.

Data from the Children's Call-Back Survey of the Behavioral Risk Factor Surveillance System has been obtained. This is the first time Indiana is able to provide detailed information on asthma among children, such as medication use, environmental exposures, and asthma-related absenteeism.

In Fall 2009, the Asthma Program and InJAC launched a continuing medical education (CME) online training for health care providers. The training is specific to understanding the key points and key differences of the updated Expert Panel Report: 3 (EPR: 3) Guidelines for the Diagnosis and Management of Asthma.

The Asthma Program promoted the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including

asthma. The State Asthma Program dedicated one staff to participate on the review committee for the 5-Star Recognition Program.

This State Performance Measure is being retired because this measure falls under the CDC funded State Asthma Program. MCH will collaborate as needed.

c. Plan for the Coming Year
This State Performance Measure is being retired.

State Performance Measure 3: *The percent of live births to mothers who smoke.*

a. Last Year's Accomplishments
Indiana State Department of Health (ISDH) continued to facilitate the legislative PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan. Dr. Nocon the Commission Chair presented information on assessment and brief intervention in pregnant women at the Indiana American College of Obestetricians/Gynecologists (ACOG) conference 3/09.

A prenatal smoking cessation training webinar on assessment and brief intervention was completed (April, 2009) and placed on the Maternal and Child Health (MCH) website. All MCH funded prenatal projects accessed the webinar and completed the pre-post test by August 31, 2009.

MCH analyzed the rate of smoking in the third trimester on a quarterly basis to determine further training needs.

The ISDH Prenatal Substance Use Prevention Program (PSUPP) continued to identify high risk, chemically dependent pregnant women and provide counseling and intervention.

PSUPP continued to: participate in (134) community events, health fairs, conferences, and other public forums, distribute 28,000 informational items about the impact of substance use on pregnant women to the public, distribute 6,500 educational items to providers, including physician's offices, indicating the importance of identifying at-risk clients, and provide support groups for women in substance use cessation.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Baby First Packets, that include information on smoking cessation, are being distributed to prenatal Indiana Family Help Line (IFHL) callers.			X	
2. MCH continues to participate in the Coalition to Prevent Smoking in Pregnancy (CPSP) to reach out to health care providers and women of childbearing age in counties with high smoking rates				X
3. MCH is analyzing prenatal smoking data through monthly data from the Notification of Pregnancy form and cessation outcomes of the new Prenatal Care Coordination program for success and				X

training needs.				
4. MCH is continuing to work with the Office of Medicaid Policy and Planning (OMPP) and the Medicaid managed care organizations to decrease smoking among pregnant women on Medicaid.			X	
5. MCH is continuing to work with the Indiana Perinatal Network (IPN) to provide prenatal smoking education to prenatal health care providers through forums and newsletters.		X		
6. The Prenatal Substance Use Prevention Program (PSUPP) continues to collaborate with Access to Recovery (ATR) to refer pregnant substance-using women to providers for needed services.				X
7. The provider resource list is being maintained and updated for public use.		X		
8.				
9.				
10.				

b. Current Activities

Baby First Packets, that includes information on smoking cessation, is being distributed to Prenatal Indiana Family Help Line (IFHL) callers.

MCH is participating in the Coalition to Prevent Smoking in Pregnancy (CPSP) to reach out to health care providers and women of childbearing age in counties with high smoking rates to decrease prematurity, low birthweight, and exposure to second smoke among infants and children.

MCH is analyzing prenatal smoking data through monthly data from the Notification of Pregnancy form and cessation outcomes of the new Prenatal Care Coordination program, Indiana Healthy Beginnings for success and training needs.

MCH is working with the Office of Medicaid Policy and Planning (OMPP) and the Medicaid Managed Care Organizations to decrease smoking among pregnant women on Medicaid.

MCH is working with the Indiana Perinatal Network (IPN) to provide prenatal smoking education to prenatal health care providers through forums and newsletters.

The PSUPP program is collaborating with Access To Recovery (ATR) to refer pregnant substance-using women to providers for needed services.

The Provider Resource List is being maintained and updated for public use.

This specific measure is being retired. A new State Performance Measure focused on reducing smoking in pregnant Medicaid mothers will replace this measure.

c. Plan for the Coming Year

This specific measure is being retired. A new State Performance Measure focused on reducing smoking in pregnant Medicaid mothers is replacing this measure

State Performance Measure 4: *The percent of black women (15 through 44) with a live birth whose prenatal care visits were adequate.*

a. Last Year's Accomplishments
Activities that impacted this Performance Objective included:

To increase the percent of black women with adequate prenatal care in 2009, prenatal projects applying for Title V funding for 2009 and 2010 were mandated to: 1) increase the number of black women entering prenatal care in the 1st trimester through a community/neighborhood outreach plan to include African American churches, 2) provide reminder/recalls for all scheduled appointments for black pregnant women, 3) identify and refer all high risk pregnant women to an appropriate high-risk provider and to prenatal care coordination. Projects were monitored and technical assistance was given those projects in need. In addition, all of the disparity counties were encouraged to facilitate "Baby showers", and "Grandmothers Teas" that included outreach, and education to the African American community. These new requirements took effect October 1, 2008.

The Office of Minority Health (OMH) media campaign "A Healthy Baby Begins with You" was implemented in the disparity counties and shared at each Baby Shower in the disparity counties. All disparity had a Baby Shower between May and July.

FIMR continued in three Indiana Counties with a focus on disparity deaths. The FIMR's continued in Marion, Vanderburgh, and Lake Counties in 2009.

Maternal and Child Health (MCH) presented "Unnatural Causes" videos and disparity information during Indiana State Department of Health (ISDH) "Lunch and Learns" every Wednesday in September. An "Unnatural Causes" Display exhibit was available for the whole month of September.

There were three Indiana Counties that had 2006 black infant mortality rates over 30/1,000 (St. Joseph, Allen, Delaware). MCH presented an analysis of birth outcomes and infants deaths in each county and worked with county coalitions and county minority coalitions to address these third world statistics.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH will increase the number of Free Pregnancy Test Projects by 100% in counties that are lower than the state average in terms of black women entering prenatal care in the first trimester.			X	
2. MCH will promote the National Healthy Mothers, Healthy Babies Coalition's free mobile information service Text4baby educational program for implementation at MCH-related clinics in the disparity counties and statewide.			X	
3. Using updated data, MCH will evaluate counties where adequate prenatal care percentages have either increased or decreased.				X
4. In high-risk counties, MCH will collaborate with the National Fatherhood Initiative to conduct two train-the-trainer workshops covering "Doctor Dad" and "When Duct Tape Won't Work" curriculums.		X		X

5. In collaboration, MCH will develop and implement a Premature Birth Initiative for addressing early preterm delivery among black women.			X	
6. The Office of Minority Health's media campaign "A Healthy Baby Begins With You" with continue to be implemented and promoted in the disparity counties as well as at Black Expo.			X	
7. MCH will continue to work with hospitals to show the "Unnatural Causes" videos and to present the life course public health perspective at grand rounds.		X		
8. MCH will develop a partnership with the March of Dimes to market the Centering Healthcare Institute's Centering Pregnancy Model's basic and level II advance facilitation workshops.				X
9. MCH will encourage the use of Social Networking Sites and tools by MCH clinics for pregnant women.		X		X
10. MCH will promote early entrance into prenatal care through certified nurse midwife Early Start Clinics in three disparity counties.	X			

b. Current Activities

Three Indiana counties have black infant mortality rates over 30/1,000 (St. Joseph, Allen, Delaware). MCH has presented a vital record analysis and GIS mapping of birth outcomes and infants deaths in each county and is continuing to work with county coalitions and county minority coalitions to address these third world statistics.

The OMH media campaign, "A Healthy Baby Begins with You", is being implemented in the disparity counties as well as at Black Expo.

MCH is collaborating with minority health coalitions in St. Joseph, Allen, Marion, Delaware, Lake, and Vanderburgh Counties to conduct a series of community conversations in Black neighborhoods to show the unnatural causes videos, provide education and empower residents to plan neighborhood activities.

MCH is working with hospitals to show the "Unnatural Causes" videos and life course perspective at grand rounds. A Grand Round presentation for OB doctors at Ball Memorial Hospital covering vital records data and the Life Course Perspective has already occurred in 2010.

MCH is collaborating with the National Healthy Mothers, Healthy Babies Coalition's free mobile information service text4baby educational program for implementation at MCH related clinics in the disparity counties and statewide. Text4baby provides free text messages three times a week with information to help mothers through their pregnancy and baby's first year.

c. Plan for the Coming Year

MCH will increase the number of Free Pregnancy Test Projects by 100% in counties that are lower than the state average in terms of black women entering prenatal care in the first trimester.

MCH will promote the National Healthy Mothers, Healthy Babies Coalition's free mobile information service text4baby educational program for implementation at MCH related clinics in the disparity counties and statewide. Text4baby provides free text messages three times a week with information to help mothers through their pregnancy and baby's first year.

Using updated data, MCH will evaluate counties where adequate prenatal care percentages have either increased or decreased.

In high-risk counties, MCH will collaborate with the National Fatherhood Initiative to conduct two train-the-trainer workshops covering "Doctor Dad" & "When Duct Tape Won't Work" curriculums in Indianapolis for Indiana healthcare and community professionals. The curriculum will teach new and prospective fathers the basic issues of well child, sick child, safe child, and injured child care. The training is designed to help men develop the attitudes, knowledge, and skills they need to get and stay involved with pregnant mother, infants, and children.

In collaboration, MCH will develop and implement a Premature Birth Initiative for addressing early preterm delivery among black women.

The OMH's media campaign, "A Healthy Baby Begins with You", will continue to be implemented and promoted in the disparity counties as well as at Black Expo.

MCH will continue to work with hospitals to show the Unnatural Causes videos and to present the life course public health perspective at grand rounds.

MCH will develop a partnership with the March of Dimes (MOD) to market the Centering Healthcare Institute's Centering Pregnancy Model's basic and Level II Advance Facilitation Workshops. These workshops will teach the skills necessary for conducting centering group care as best practices in 10 Indiana counties that have a (1) low percentage of black women who receive adequate prenatal care, and (2) high incidents of LBW births and infant mortality.

MCH will encourage the use of Social Networking Sites (SNS) and tools by MCH clinics for pregnant women.

MCH will promote early entrance into prenatal care through certified nurse midwife Early Start clinics in three disparity counties.

State Performance Measure 5: *The percentage of children age 0 to 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter.*

a. Last Year's Accomplishments

Indiana Lead and Healthy Homes Progam (ILHHP) continued efforts to improve the screening rate of Medicaid recipient children. Information on MCO screening rates is made available in a formal data exchange between ILHHP and Medicaid.

410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING was revised to reflect current recommendations from the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) and changes due to SEA 143.

ILHHP worked to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.

Eight local health departments are Medicaid providers and actively sought reimbursement for all lead related services.

ILHHP continued to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.

ILHHP increases awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information

regarding consumer product safety issues.

Six million dollars was awarded to City of Gary Health Department and the Elkhart County Health Department in Indiana to address lead hazards through President Obama's American Recovery Act of 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ILHHP conducts training on the revised administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.				X
2. ILHHP works to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.				X
3. ILHHP works to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.		X		
4. ILHHP continues efforts to affect an increase in the percent of Medicaid screened children by encouraging Medicaid reimbursement for testing, case management, and environmental inspection.			X	
5. ILHHP improves data collections and comparisons with other programs such as Medicaid and WIC, use of the I-LEAD web application to produce consistent and effective risk assessments and environmental follow-up.				X
6. ILHHP increases awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.		X		
7. ILHHP will work to introduce comprehensive lead legislation focusing on retaliatory evictions for contacting local health departments and issues surrounding lead hazards in rental property.				X
8. ILHHP will increase the number of risk assessors in Indiana by 10 % to 272 by December 31, 2011.				X
9. ILHHP will increase the number of homes remediated for lead hazards by 10% to 1,367 by December 31, 2011.		X		
10. ILHHP will increase the number of homes where abatement activities are conducted by 10% per 326 IAC 23 to 20 homes by December 31, 2011.		X		

b. Current Activities

Conducted training on the revised administrative rule 410 IAC 29.

ILHHP worked to improve case management of lead poisoned children by continuing the systematic training of local health department staff.

ILHHP is working with the Indiana Lead-Safe Housing Advisory Council and the Indiana General Assembly to introduce comprehensive lead legislation focusing on retaliatory evictions for contacting local health departments and issues surrounding lead hazards in rental property.

ILHHP is working to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.

ILHHP decreased the percent of children with elevated blood lead levels by increasing primary prevention activities including increasing the overall number of environmental inspections and investigations; increasing the number of housing units becoming lead safe; helping to increase the lead hazard remediation grants in the state; improving training and increasing the number of licensed lead professionals; improving enforcement of existing abatement regulations, and an expanded mission to include an overall healthy homes approach to environmental case management.

ILHHP continued efforts to increase the percent of Medicaid screened children; improve lead program data collection and analysis; and increase awareness and outreach efforts.

This SPM will change and focus on children 72 months and younger.

c. Plan for the Coming Year
ILHHP will conduct training on the revised administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.

ILHHP will work to improve case management of lead poisoned children by continuing the systematic training of local health department staff.

ILHHP will work with the Indiana Lead-Safe Housing Advisory Council and the Indiana General Assembly to introduce comprehensive lead legislation focusing on retaliatory evictions for contacting local health departments and issues surrounding lead hazards in rental property.

ILHHP will work to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.

ILHHP will decrease the percent of children with elevated blood lead levels by increasing primary prevention activities including increasing the overall number of environmental inspections and investigations; increasing the number of housing units becoming lead safe; helping to increase the lead hazard remediation grants in the state; improving training and increasing the number of licensed lead professionals; improving enforcement of existing abatement regulations, and an expanded mission to include an overall healthy homes approach to environmental case management.

ILHHP will continue efforts to increase the percent of Medicaid screened children; improve lead program data collection and analysis; and increase awareness and outreach efforts.

This SPM is changing to read, "The percentage of children 72 months and younger with blood lead levels equal to or greater than ten micrograms per deciliter."

State Performance Measure 6: *The proportion of births occurring within 18 months of a previous birth to the same birth mother.*

a. Last Year's Accomplishments
FY 2009 Performance Measure: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 14% in 2009.

The latest available data is from the 2006 vital records. In 2006, 11.9% of mothers had a birth that was within 18 months of previous birth.

Developed media messages that address interpregnancy intervals. Consultants from Title X have met with coalitions in disparity counties about developing county level programs.

Work with the Indiana State Department of Health's (ISDH) Office of Women's Health, the Indiana Office of Medicaid Policy and Planning (OMPP), Indiana Perinatal Network (IPN) State Perinatal Advisory Board, and the Indianapolis Women's Center of Excellence to develop an "Every Woman Every Time" movement with provider trainings, consumer media and marketing. The Maternal and Child Health (MCH) perinatal consultant presented the "Every Woman Every Time" preconception program to Anthem, The OMPP Neonatal Quality Outcomes Committee, the program development and policy committee of the Women's Center of Excellence, and the ISDH Office of Women's Health. None of these partners were interested in development of a preconception program in 2009. How to pay for it was the number one barrier.

On 7-15-09 Sarah Brown, CEO of the National Campaign to Prevent Teen and Unplanned Pregnancies, presented ""Teen Pregnancy and Unplanned Pregnancy in Young Adults: Why It All Matters" at the State Perinatal Advisory Meeting before attending The Indiana Black Expo for a special adolescent program.

IPN hosted a second "Controversies and Innovations in Perinatal Health", State Perinatal Forum March 25-26, 2009 with a focus on access to care. Unintended pregnancies were discussed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. IPN will work with state stakeholders to implement two (2) of the recommendations in the State Perinatal Advisory Board consensus document, “Best Intentions: Unplanned Pregnancy.		X		
2. Continue to work with the ISDH Office of Women’s Health, the Indiana OMPP, IPN and the Indianapolis Women’s Center of Excellence to develop an “Every Woman Every Time” movement with provider trainings, consumer media and marketing.				X
3. MCH and the State Perinatal Advisory Board will explore the best way to operationalize the concept of interconception care for health care providers and implement at least one strategy to promote “Every Woman Every Time messages.		X		
4. MCH will continue to work with disparity counties to implement A Healthy Baby Begins with You campaign and messages about healthy interpregnancy intervals..			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2010 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 12% in 2009. The latest available data is from the 2006 vital records. In 2006, 11.9% of mothers had a birth that was within 18 months of previous birth.

IPN will work with state stakeholders to implement two of the recommendations in the State Perinatal Advisory Board consensus document, "Best Intentions: Unplanned Pregnancy". IPN is working closely with Medicaid on the Family Planning Waiver.

Continue to work with the ISDH Office of Women's Health, the Indiana OMPP, IPN, and the Indianapolis Women's Center of Excellence to develop an "Every Woman Every Time" movement with provider trainings, consumer media and marketing

MCSHC and the State Perinatal Advisory Board and others will explore the best way to operationalize the concept of interconception care for health care providers and will implement at least one strategy (vitamins for the whole family- all family members take a Flintstone vitamin together -- to promote healthy families and folic acid for women, Rx pads for physicians to give all to women of childbearing age in their practice with "Every Woman Every Time messages.)

MCH will work with Title X to implement media campaign. MCSHC will continue to work with disparity counties to implement A Healthy Baby Begins with You campaign.

c. Plan for the Coming Year

FY 2011 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 10% in 2011.

MCH is changing the main focus of this objective to include both preconception and Interconception activities. Research shows that taking a life course perspective and address social determinants that lead to poor health is a useful approach in changing lifestyles, knowledge and behaviors. Indiana has not been successful in providing preconception and interconception programs for our women of childbearing age. Through the next five years MCH will take a life course approach to unintended pregnancy and birth spacing by working with a coalition of state and local representative to identify what works best and how to get appropriate messages out to those women and men at highest risk.

Develop a State Family Planning work group in collaboration with the Indiana Family Health Council Title X program to assist MCH in development of statewide preconception and Interconception program. Members of the work group will include Title X, Planned Parenthood, Office of Medicaid Policy and Planning, Title XX, Indiana Perinatal Network, Indiana University School of Medicine, Women's Center of Excellence, Managed Care Organizations, ISDH Offices of Women's Health, Minority Health, Nutrition and Physical Activity, HIV, STIs, Adult Immunization, INCASA, health care professionals from state and local agencies. The work group will be charged to:

IPN will conduct training updates on preconception best practice models and new family planning methods with Title V funded projects.

Collect and evaluate best practice models for improving birth spacing and decreasing unintended pregnancies.

Consolidate and disseminate existing health care professional guidelines to include, recommended guides for preconception / interconception screenings, interventions, and health promotion.

Monitor status of Medicaid Family Planning Waiver and work with state partners and FP work

group to develop social marketing plan for Family Planning Waiver implementation.

Increase health provider awareness (primary care providers, pediatricians, OB/GYN, family planning), regarding the importance of addressing preconception health among all women of childbearing age in their practice, through state summits, guidelines, and tool development yearly:

Conduct a statewide summit for health care providers on integrating preconception and interconception health care within medical practices by 9/30/2011.

Develop and disseminate practical screening tools for public health and primary care settings with emphasis on the 10 areas for preconception risk assessment.

Develop consumer-focused research to identify terms that the public understands and to develop messages promoting preconception health and reproductive awareness.

State Performance Measure 7: *Number of community/neighborhood partnerships begun in 5 targeted counties to identify perinatal disparities.*

a. Last Year's Accomplishments
Delaware County was added as the fourth disparity county with a black infant mortality rate of 32. Maternal and Child Health (MCH) consultant has attended two TA meetings in February and April to share data and GIS maps and assist in planning.

The "Healthy Baby Begins with You" materials were disseminated to St. Joseph, Lake, Marion and Vanderburgh counties.

The focus of this year's MCH booth at Black Expo is Children with Special Health Care Needs. Disparity information was also distributed.

MCH Consultant has attended coalition meetings in Lake, Marion, St. Joseph and Delaware counties to share updated data and state plans. MCH and Purdue will complete a PPOR analysis in the fourth quarter in St. Joseph, Allen and Elkhart counties to further define areas of need.

Provided five perinatal trainings on at least six topics for a total of 25 trainings in disparity and focus counties.

Increased outreach among priority counties to bring in new Indiana Perinatal Network (IPN) members, formed/expanded local perinatal networks/coalitions to utilize current infrastructure in improving perinatal outcomes. Explored use of videoconferencing to include more members in quarterly State Perinatal Advisory Board Meetings.

To increase the percent of black women with adequate prenatal care in 2009, prenatal projects applying for Title V funding for 2009 and 2010 were mandated to increase the number of black women entering prenatal care in the 1st trimester through a community/neighborhood outreach plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with local minority health coalitions in targeted			X	

counties to facilitate community conversations in which "Unnatural Causes" videos are shown and discussed.				
2. The Indiana Multistate Learning Collaborative on vital record quality improvement is targeting St. Joseph, Allen, and Elkhart Counties.				X
3. Show "Unnatural Causes" videos during hospital grand rounds at hospitals interested in the disparity counties.		X		
4. All of the disparity counties will facilitate town hall meetings in minority neighborhoods to identify barriers to appropriate health care and results will be used to update county disparity plans of action.			X	X
5. MCH, Office of Public Affairs, and Office of Minority Health are collaborating on a Black perinatal disparity media campaign adapted from “A Healthy Baby Begins With You” to be used in St. Joseph County.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Collaborating with local minority health coalitions in the targeted counties to facilitate community conversations in which Unnatural Causes videos are shown and discussed. This will serve as a beginning of neighborhood empowerment and action.

Sharing PPOR results with St. Joseph, Allen and Elkhart counties and use to spearhead action on disparity plans.

Showing "Unnatural Causes" videos during hospital grand rounds at interested hospitals.

Collaborating with Purdue University to implement the Multi-State Learning Collaborative process in identified disparity counties.

This SPM is being retired because the objectives were met.

c. Plan for the Coming Year
This SPM is being retired because the objectives were met.

State Performance Measure 8: *The percentage of high school students who are overweight or at risk.*

a. Last Year's Accomplishments
The DNPA formed a statewide task force of obesity prevention partners as part of the Indiana Healthy Weight Initiative. As of May 8, 2009, the DNPA held two meetings with the Indiana Healthy Weight Initiative Task Force. Two more full task force meetings and multiple workgroup meetings will be held during fiscal year 2009.

Obesity prevention is included in the Indiana Adolescent Health plan published in May, 2009.

ISDH supported a legislative proposal brought before the Indiana General Assembly that would require school-based BMI collection in grades 3, 5, and 7.

The DNPA continued to support the expansion of coordinated school health programs.

DNPA collaborated with the Indiana Department of Education (IDOE). Representatives from IDOE have participated in the Indiana Healthy Weight Initiative Task Force.

DNPA encouraged schools and communities to implement the We Can! ™ Program. We Can!™, or "Ways to Enhance Children's Activity & Nutrition", is a national program designed to help children maintain a healthy weight by practicing three important behaviors: improved food choices, increased physical activity and reduced screen time. Additional information about this program can be found at www.nhlbi.nih.gov/health/public/heart/obesity/wecan.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Indiana Healthy Weight Initiative (IHWI) and the Division of Nutrition and Physical Activity (DNPA) is completing development of a state plan for obesity prevention that addresses issues related to childcare, school settings, and special populations.				X
2. IHWI and DNPA will publish and disseminate a state plan for obesity prevention by the end of June 2010.				X
3. IHWI and DNPA will also complete implementation, evaluation, and marketing plans related to the obesity prevention plan.			X	
4. DNPA and Maternal and Child Health (MCH) are collaborating in the sampling of schools and collection of data in the administration of the Youth Risk Behavior Survey (YRBS). The divisions of ISDH are working together to disseminate the data.				X
5. DNPA, MCH and the IHWI Task Force are investigating strategies for using MCH adolescent clinics as a pilot setting for obesity prevention interventions.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Indiana Healthy Weight Initiative Task Force and the DNPA will continue to develop a state plan for obesity prevention that addresses issues related to childcare and school settings and to specific populations, including childbearing women.

By the end of August 2010, the Indiana Healthy Weight Initiative and the DNPA will complete, publish, and disseminate a state plan for obesity prevention.

In addition to completing the state plan by August 2010, the Indiana Healthy Weight Initiative and the DNPA will complete related implementation, evaluation, and marketing plans.

DNPA and MCH will work together to administer the YRBS. The sample of high schools will be drawn in summer 2009, but surveys will not actually be administered until fall 2009. Once the data are returned to ISDH, the two divisions will work together to disseminate the data and promote policies and programs based on the results.

DNPA, MCH, and the Indiana Healthy Weight Initiative Task Force will investigate strategies for using the MCH adolescent clinics as a pilot setting for obesity prevention interventions.

This SPM will be retired. The new SPM will change to read, "The percentage of high school students who are obese."

c. Plan for the Coming Year

This SPM will be retired. The new SPM will change to read, "The percentage of high school students who are obese."

E. Health Status Indicators

Introduction

Indiana has continued to submit the Health Status Indicators annually. Hoosiers or anyone else can access these statistics included in the grant from the ISDH website. Some of these same data are also found on the website in the statistics that the ISDH Epidemiology Research Center provides. Hoosiers may access whichever data is most user-friendly.

Several of the Health Status Indicators, including STD, injury, population demographics and low birth weight, were used as benchmarks to determine which counties in Indiana were in the highest need of attention for these and all other issues. This analysis will be used to decide the criteria for local funding over the next 5 years.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.3	8.2	8.5	8.3	8
Numerator	7249	7334	7614	7262	
Denominator	87088	89404	89719	87520	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

FY2009 data not yet available. Estimate provided based on trend analysis.

Notes - 2008

Source of data: ISDH ERC

Notes - 2007

Source of data: ISDH ERC

Narrative:
In 2008, provisional data indicate that the number of live births weighing less than 2,500 grams was 8.3%. This data element was derived from trend analysis, as the 2008 final data are not available at this time. This percentage represents no significant change from the prior three years. These data were obtained from the ISDH Epidemiology Resource Center (ERC), utilizing the Electronic Birth Certificates.

Health Status Indicator #01A supports MCH's focus on efforts to improve factors that contribute to low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on this measure, it serves as a monitoring tool for our programs and allows us to evaluate the success of the programs involved. The multiyear trend shows a slight increase or stabilized rates for low birth weight for white, black and total births.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.5	6.5	6.8	6.5	6.3
Numerator	5464	5639	5861	5512	
Denominator	84064	86467	86750	84612	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis.

Notes - 2008
Source of data: ISDH ERC

Notes - 2007
Source of data: ISDH ERC

Narrative:
The percent of live singleton births weighing less than 2,500 in 2008 was 6.3%, as derived from trend analysis. This percentage, which is only provisional at this time, represents a slight decrease from the past three years (6.5%). These data were obtained from the Electronic Birth Certificates, and from the ISDH ERC.

As noted with Health Status Indicator #01A, HIS #01B supports a focus specifically on efforts to improve factors that contribute to low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on these measures it serves as a monitoring tool for our programs, and allows us to evaluate the success of the programs involved. The multiyear trend shows a slight decrease or stabilized rates for low birth weight for

total births.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.5	1.4	1.5	1.4	1.3
Numerator	1336	1271	1343	1244	
Denominator	87088	89404	89719	87520	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis.

Notes - 2008
Source of data: ISDH ERC

Notes - 2007
Source of data: ISDH ERC

Narrative:
Provisional data for 2008 indicate that 1.3% of live births weighed less than 1,500 grams. The three previous years of final data were 1.5% in 2005, 1.4% in 2006, and 1.5% in 2007. These data were also obtained from the electronic Birth Certificates and the ISDH ERC.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.1	1.1	1.1	1.1	1
Numerator	963	959	979	923	
Denominator	87088	89404	86750	84612	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis.

Notes - 2008

Source of data: ISDH ERC

Notes - 2007
Source of data: ISDH ERC

Narrative:
The percent of live singleton births weighing less than 1,500 grams was 1.0% in 2008 (provisional data). Final data for the previous 3 years indicated 1.1% each year, according to data provided by the ISDH ERC. HSI #02A & #02B will continue to be used as a monitoring tool, and when appropriate, the statistics can also be used for evaluation.

Health Status Indicators 2A, and 2B -- very low weight births, and very low weight singleton births -- directly provide information on that segment of Indiana's population, and supports a focus specifically on efforts to improve factors that contribute to very low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on these measures it serves asa monitoring tool for our programs, and allows us to evaluate the success of the programs involved. The multiyear trend shows that rates are stable for very low birth weight for white, black and total births.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	11.3	11.3	10.6	11.2	10.9
Numerator	150	147	139	147	
Denominator	1326607	1301093	1310331	1311912	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis.

Notes - 2008
Source of data: ISDH ERC

Numerator calculated depending on the provided rate and denominator.

Notes - 2007
Source of data: ISDH ERC

Numerator calculated depending on the provided rate and denominator.

Narrative:

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger for 2008 (provisional) is 11.2. The most current final data indicates the death rate due to unintentional injuries among children aged 14 years and younger was 10.6 in 2007. Rates were calculated using population data from the U.S. Census Bureau. The multiyear trends show that the death rate due to unintentional injury for 14 and under have stayed stable.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.3	3.5	3.4	3.5	3.4
Numerator	44	46	44	46	
Denominator	1326607	1301093	1310331	1311912	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis.

Notes - 2008
Source of data: ISDH ERC.

Notes - 2007
Source of data: ISDH ERC.

Narrative:
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes was 3.4 in 2007, and provisional data indicate 3.3 for 2008. The numbers are very small and unstable, but the death rate has remained stable for children 0-14 in motor vehicle crashes in the multiyear trend analysis.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.2	25.9	21.6	22.1	21.6
Numerator	235	231	190	194	
Denominator	897927	892372	881332	878632	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis.

Notes - 2008
Source of data: ISDH ERC

Notes - 2007
Source of data: ISDH ERC

Narrative:
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years was 21.6 in 2007. Provisional data for 2008 shows a 23.4% death rate for this indicator in 2008. The death rates from motor vehicle crashes among youth have decreased from 26.2 in 2005 and 25.9 in 2006. The numbers have been volatile for death rate for 15-24 year olds due to motor vehicle crashes, but the multiyear trends show a slight decrease in the rate.

These data were obtained through the ISDH Epidemiology Resource Center, from Electronic Death Certificates. Rates were calculated using population data from the U.S. Census Bureau.

Health Status Indicators 3A, 3B, and 3C -- the death rate per 100,000 from, respectively, unintentional injuries to children 14 and younger, unintentional injuries to children 14 and younger due to motor vehicle crashes, and unintentional injuries to children 15 - 24 due to motor vehicle crashes -- directly provide information related to child mortality, both in motor vehicle accidents, and due to overall unintentional injuries in the youngest segment of the population through age14. This supports a focus on addressing causes of those fatal injuries and allows for targeted educational programs to encourage preventive behaviors, e.g., proper car seat use, proper seat belt use. It serves as a monitoring tool for the success of those programs, and allows us to evaluate those programs in terms of effect on the target populations.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	118.2	112.6	111.9	116.0	111.9
Numerator	1568	1465	1466	1518	
Denominator	1326607	1301093	1310331	1308397	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2008
Source of data: ISDH ERC

Notes - 2007
Source of data: ISDH ERC

Narrative:
Non-fatal injuries among children aged 14 years and younger occurred at a rate of 111.9 per 100,000 in 2007; and analysis of provisional data indicate a rate of 116.0 per 100,000 in 2008.

Health Status Indicators 4A, 4B, and 4C -- identical to 3A, 3B, and 3C, except as applied to nonfatal injuries -- directly provide much of the same information, support much of the same programmatic approaches, and also serve as a monitoring and evaluation tool as to the success of these approaches. The difference from HIS's 3A, 3B, and 3C is that success of the programs and approaches can be more reliably measured as the numbers of nonfatal injuries are greater than the numbers of fatal injuries. However, there are not enough years of data to establish a specific trend for HSI's 4A, 4B, and 4C at present. A few more data points, which will be collected over the next few years, will allow more detailed analysis. The multiyear trend shows the rate of all nonfatal injuries to children 14 and under to be stable.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	17.6	16.1	16.3	15.0	14.9
Numerator	233	210	213	196	
Denominator	1326607	1301093	1310331	1308397	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2008
Source of data: ISDH ERC

Notes - 2007
Source of data: ISDH ERC

Narrative:
In 2007, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger was 16.3. For 2008, provisional data indicate a rate of 15.7 per 100,000. These data were obtained from the Indiana Hospital Association and all hospital discharge data from inpatient hospital discharges. Rates were calculated using population data from the U.S. Census Bureau. The multiyear trend shows the rate of all nonfatal injuries due to motor vehicle crashes to children 14 and under to be stable.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	90.2	82.0	74.0	74.0	73
Numerator	810	732	652	648	
Denominator	897927	892372	881322	876171	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH ERC, available by end of August 2009.

Notes - 2008
Source of data: ISDH ERC

Notes - 2007
Source of data: ISDH ERC

Narrative:
The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years has improved from 90.2 in 2005, to 82.0 in 2006, and 74.0 in 2007. Provisional data indicates that the 2008 rate is 75.8. These data are from all inpatient hospital discharges, reported by the Indiana Hospital Association. Rates again, were calculated using population data from the U.S. Census Bureau. The multiyear trend shows the rate of all nonfatal injuries due to motor vehicle crashes to youth aged 15-24 to be stable.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Indicator	26.8	26.2	26.9	28.9	28.4
Numerator	5838	5805	5965	6341	6243
Denominator	217646	221589	221589	219488	219488
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis. Source of data will be ISDH HIV/STD program, ISDH ERC

Notes - 2008
Source of data: ISDH HIV/STD program, ISDH ERC

Notes - 2007
Source of data: ISDH HIV/STD program, ISDH ERC

Narrative:
As reported by the ISDH Epidemiology Resource Center (ERC), the rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia was 26.9 in 2007. Provisional data for 2008 shows a rate of 28.9 reported cases of Chlamydia per 1,000 women aged 15 through 19 years.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.2	8.4	8.5	8.7	8.8
Numerator	8862	9018	9141	9422	9530
Denominator	1083072	1076076	1076076	1078262	1078262
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
FY2009 data not yet available. Estimate provided based on trend analysis. Source of Data will be ISDH HIV/STD program, ISDH ERC.

Notes - 2008
Source of Data will be ISDH HIV/STD program, ISDH ERC.

Notes - 2007
Source of Data: ISDH HIV/STD program, ISDH ERC.

Narrative:
Among women aged 20 through 44 years of age, 8.5 per 1,000 had a reported case of Chlamydia in 2007. The provisional figures obtained from the ISDH ERC for 2008 indicate a rate of 8.7.

Health Status Indicators 5A and 5B -- the rate per 1,000 women with a reported case of Chlamydia among, respectively, women aged 15 through 19 and women aged 20 through 44 -- provides information related to one of the major sexually transmitted diseases in Indiana's women, both the teen-age and the young adult segment. This problem is growing among both populations. The upward trend supports the Indiana State Department of Health assigning a greater priority and more resources to combat this problem.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	91603	74642	10654	398	1449	0	0	4460
Children 1 through 4	360005	296287	39682	1136	5536	0	0	17364
Children 5 through 9	442108	365312	48441	1412	6689	0	0	20254
Children 10 through 14	442182	367895	49255	1364	6002	0	0	17666
Children 15 through 19	458807	385987	50982	1510	5586	0	0	14742
Children 20 through 24	435569	369122	43723	1491	7157	0	0	14076
Children 0 through 24	2230274	1859245	242737	7311	32419	0	0	88562

Notes - 2011

Narrative:
The graph enumerating infants and children aged 0 through 24 years by sub-populations of age group, race and ethnicity is available on Form 21: Health Status Indicators Demographic Data State: IN HSI #06A and HSI #06B. Please note that Native Hawaiian and Pacific Islanders are included in the Asian sub-population group. The sub-population "Other and Unknown" is included with the "More than One Race Reported" sub-population.

These data were obtained through the ISDH Epidemiology Resource Center. Of note is the increase in live births among the Hispanic sub-population from 6.1% of live births in 2005 to 9.9% of live births in 2007.

Health Status Indicators 6A and 6B give total population by race, ethnicity, and age. This shows what segments of our population are experiencing the most growth and thus must be given more

weight in programmatic terms. For example, Indiana is one of several states with an increasing Hispanic population. This knowledge helps us develop more multi-cultural programs, cultural awareness training, etc.

In HSI 6A and 6B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	80603	9153	0
Children 1 through 4	316181	37152	0
Children 5 through 9	396653	37354	0
Children 10 through 14	405338	29478	0
Children 15 through 19	426913	24798	0
Children 20 through 24	402624	24297	0
Children 0 through 24	2028312	162232	0

Notes - 2011

Narrative:
The graph enumerating infants and children aged 0 through 24 years by sub-populations of age group, race and ethnicity is available on Form 21: Health Status Indicators Demographic Data State: IN HSI #06A and HSI #06B. Please note that Native Hawaiian and Pacific Islanders are included in the Asian sub-population group. The sub-population "Other and Unknown" is included with the "More than One Race Reported" sub-population.

These data were obtained through the ISDH Epidemiology Resource Center. Of note is the increase in live births among the Hispanic sub-population from 6.1% of live births in 2005 to 9.9% of live births in 2007.

Health Status Indicators 6A and 6B give total population by race, ethnicity, and age. This shows what segments of our population are experiencing the most growth and thus must be given more weight in programmatic terms. For example, Indiana is one of several states with an increasing Hispanic population. This knowledge helps us develop more multi-cultural programs, cultural awareness training, etc.

In HSI 6A and 6B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	109	67	42	0	0	0	0	0
Women 15 through 17	2954	2242	674	3	3	4	0	28
Women 18 through 19	6977	5580	1312	12	16	17	0	40
Women 20 through 34	70562	61333	7486	94	1021	262	0	366
Women 35 or older	9096	7924	786	7	271	51	0	57
Women of all ages	89698	77146	10300	116	1311	334	0	491

Notes - 2011

Narrative:
A graph depicting live births to women enumerated by maternal age, race and ethnicity can also be found in Form 21: Health Status Indicators Demographic Data State: IN -- HSI #07A and HSI #07B. There have been no significant changes in these data when compared to previous years.

Health Status Indicators 7A and 7B give us similar information, but specifically related to birth rates. This allows for us to specifically aim the multi-cultural programs and awareness toward pregnant women and newborn programs.

HSI 7A and 7B also provide information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	91	18	0
Women 15 through 17	2518	425	11
Women 18 through 19	6251	712	14
Women 20 through 34	63606	6848	108
Women 35 or older	8290	785	21
Women of all ages	80756	8788	154

Notes - 2011

Narrative:
A graph depicting live births to women enumerated by maternal age, race and ethnicity can also be found in Form 21: Health Status Indicators Demographic Data State: IN -- HSI #07A and HSI #07B. There have been no significant changes in these data when compared to previous years.

Health Status Indicators 7A and 7B give us similar information, but specifically related to birth rates. This allows for us to specifically aim the multi-cultural programs and awareness toward pregnant women and newborn programs.

HSI 7A and 7B also provide information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	601	397	153	0	5	0	0	46
Children 1 through 4	117	82	30	0	0	0	0	5
Children 5 through 9	68	59	6	0	0	0	0	3
Children 10 through 14	77	64	12	0	0	0	0	1
Children 15 through 19	295	236	45	0	1	0	0	13
Children 20 through 24	381	281	81	0	1	1	0	17
Children 0 through 24	1539	1119	327	0	7	1	0	85

Notes - 2011

Narrative:
The graph of deaths to infants and children aged 0 through 24 years of age, enumerated by age subgroup, race and ethnicity can be found in Form 21: Health statues Indicators Demographic Data State: IN - HSI #08A & #08B. These data were provided by the ISDH ERC and Electronic Death Certificates.

As with HSI's 6A through 7B, HSI 8A&B provide us with information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to

deal with these disparities.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	528	67	6
Children 1 through 4	107	9	1
Children 5 through 9	65	3	0
Children 10 through 14	73	3	1
Children 15 through 19	273	19	3
Children 20 through 24	348	27	6
Children 0 through 24	1394	128	17

Notes - 2011

Narrative:
The graph of deaths to infants and children aged 0 through 24 years of age, enumerated by age subgroup, race and ethnicity can be found in Form 21: Health statues Indicators Demographic Data State: IN - HSI #08A & #08B. These data were provided by the ISDH ERC and Electronic Death Certificates.

As with HSI's 6A through 7B, HSI 8A&B provide us with information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1794705	1490123	199014	5820	25262	0	0	74486	2008
Percent in household headed by single parent	33.7	29.3	69.2	0.0	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant)	100.0	47.0	40.0	0.2	1.2	0.0	0.0	11.5	2008

families									
Number enrolled in Medicaid	728832	0	0	0	0	0	0	728832	2009
Number enrolled in SCHIP	36781	0	0	0	0	0	0	36781	2009
Number living in foster home care	12957	8026	4610	206	19	16	22	58	2008
Number enrolled in food stamp program	342791	202247	99409	0	3428	0	0	37707	2008
Number enrolled in WIC	206723	155105	37480	1105	2596	335	10095	7	2009
Rate (per 100,000) of juvenile crime arrests	22557.0	66.2	30.8	0.3	0.1	0.1	0.0	2.5	2009
Percentage of high school drop-outs (grade 9 through 12)	100.0	75.4	20.5	0.0	0.9	0.0	2.7	0.5	2009

Notes - 2011
Total number of families in TANF 85948

Total enrolled in food stamps were 350052

Total high school drop outs were 5040

Narrative:
Please reference the graph of infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State Programs enumerated by race and ethnicity in Form 21: Health Status Indicators Demographic Data State: IN -- HIS #09A & #09B. These data were obtained from the Office of Medicaid Policy (OMPP) and Planning, the WIC Program, and the ISDH Epidemiology Resource Center.

Health Status Indicator 9 is the most diverse of the Health Status Indicators, encompassing racial and ethnic breakdowns among the following populations for children 0-19 years of age:

Percent in households headed by single parent
Percent in TANF (grant) families
Number enrolled in Medicaid
Number enrolled in SCHIP
Number living in foster home care
Number enrolled in food stamp program
Number enrolled in WIC
Rate per 100,000 of juvenile crime arrests
Percentage of high school dropouts, grades 9 through 12

Each one of these involves specific programs, some internal to ISDH and some external. We have some programs and some targets for the disparities revealed by these data. This allows for

monitoring results and evaluating what effect our programs have on these varying areas.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1625688	137935	0	2008
Percent in household headed by single parent	29.3	34.9	0.0	2008
Percent in TANF (Grant) families	87.0	10.3	0.0	2008
Number enrolled in Medicaid	0	0	728832	2009
Number enrolled in SCHIP	0	0	36781	2009
Number living in foster home care	11562	1088	307	2008
Number enrolled in food stamp program	308086	34705	0	2008
Number enrolled in WIC	167960	38756	7	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	92.3	7.7	0.0	2008

Notes - 2011
Data is not available.

Narrative:
Please reference the graph of infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State Programs enumerated by race and ethnicity in Form 21: Health Status Indicators Demographic Data State: IN -- HIS #09A & #09B. These data were obtained from the Office of Medicaid Policy (OMPP) and Planning, the WIC Program, and the ISDH Epidemiology Resource Center.

Health Status Indicator 9 is the most diverse of the Health Status Indicators, encompassing racial and ethnic breakdowns among the following populations for children 0-19 years of age:

Percent in households headed by single parent
Percent in TANF (grant) families
Number enrolled in Medicaid
Number enrolled in SCHIP
Number living in foster home care
Number enrolled in food stamp program
Number enrolled in WIC
Rate per 100,000 of juvenile crime arrests
Percentage of high school dropouts, grades 9 through 12

Each one of these involves specific programs, some internal to ISDH and some external. We have some programs and some targets for the disparities revealed by these data. This allows for monitoring results and evaluating what effect our programs have on these varying areas.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1278627
Living in urban areas	1234536
Living in rural areas	529087
Living in frontier areas	0
Total - all children 0 through 19	1763623

Notes - 2011

Narrative:
Form 21: Health Status Indicators Demographic Data State: IN -- HIS #10 provides information about the geographic living areas for Indiana's resident children aged 0 through 19 years. There is overlap between urban areas and metropolitan areas, which house 70% of Indiana's children. Only 30% of Indiana children live in rural areas. Each living area represents unique challenges and benefits. For example, transportation to an adequate care facility may be more difficult in a rural area due to distance, whereas specific health problems (e.g., lead poisoning) may be more prevalent in a metropolitan setting due to a higher concentration of old housing with lead-based paint.

These data were provided by the ISDH ERC and from the U.S. Census Bureau.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	6376792.0
Percent Below: 50% of poverty	8.2
100% of poverty	13.0
200% of poverty	31.5

Notes - 2011
Provision figure based on previous data provided by ERC and US Census Bureau.

Narrative:
Health Status Indicators 11 deals with the percentage of people living in poverty. Again, as in Health Status Indicator 10, poverty reflects unique challenges, and the different conditions of poverty--50% of poverty level versus 100% of poverty level versus 200% of poverty level--call for different programmatic approaches. While the basic factor, money, is the core of what is involved, there is a significant difference in whether a mother or child can pay for a service at all, even on a sliding scale, or whether that service has to be provided with no direct charge to the person served. The intent is to lower the number of persons living in poverty, but more specifically to raise those in extreme poverty to at least some level higher. Indiana has succeeded in lowering the percentage in the worst poverty category, which has caused some growth in the higher poverty level groups. By continuing to address the issues of health needs for all women and

children in the state, and adding an additional focus as to the income aspect, it is anticipated that in the future all levels of poverty, from 200% of poverty level and lower, will decrease.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1584681.0
Percent Below: 50% of poverty	18.0
100% of poverty	27.2
200% of poverty	40.0

Notes - 2011
Population calculations are based on 0-18 years old; this figure is the total poulation of that age range rather than 0-19 years old so the data can be directly comparable.

Source of data: USBC, ISDH - ERC

Source of data: OMPP

Source of data: OMPP

Source of data: Kids Count, Anne E. Casey Foundation

Narrative:
In 2008, 27.2% of children under age 18 years lived in homes with income levels less than 100% of poverty, and 40% of children lived in homes at less than 200% of the federal poverty level. These data are from www.Kidscount.org and www.statehealthfacts.org.

Health Status Indicators 12 deals with the percentage of people ages 0 through 19 years living in poverty. Again, as in Health Status Indicator 10 & 11, poverty reflects unique challenges, and the different conditions of poverty--50% of poverty level versus 100% of poverty level versus 200% of poverty level--call for different programmatic approaches. While the basic factor, money, is the core of what is involved, there is a significant difference in whether a mother or child can pay for a service at all, even on a sliding scale, or whether that service has to be provided with no direct charge to the person served. The intent is to lower the number of persons living in poverty, but more specifically to raise those in extreme poverty to at least some level higher. Indiana has succeeded in lowering the percentage in the worst poverty category, which has caused some growth in the higher poverty level groups. By continuing to address the issues of health needs for all women and children in the state, and adding an additional focus as to the income aspect, it is anticipated that in the future all levels of poverty, from 200% of poverty level and lower, will decrease.

F. Other Program Activities

In terms of maternal and child health, the effectiveness of our interventions and programs is an overriding issue. Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this

phenomenon, it is an issue we are addressing in a number of ways as discussed in the following paragraphs.

As discussed in Section III, State Overview, Indiana is near the bottom of all states in receipt of federal health dollars. Indiana ranks 48th for the amount of federal funding for public health from the CDC in FY 2009, 50th for Federal funding from HRSA, and 47th for the amount states provide for public health services. This lack of funding adversely impacts capacity. To combat these low funding levels, we will be examining all funded projects in the coming year to ensure their effectiveness.

Additionally, we are aggressively seeking additional grants that will allow Indiana to supplement Title V funding for maternal and child health programs. Examples of grants for which we are applying include:

Teen Outreach Program (TOP) -- The Indiana State Department of Health (ISDH), in partnership with the Indiana Department of Education (DOE), Health Care Education and Training, Inc. (HCET) and the Center for Sexual Health Promotion (CSHP) at Indiana University recently submitted an application to the newly created federal Office of Adolescent Health to implement the Teen Outreach Program (TOP), an evidence-based, youth development and community service focused program to prevent teen pregnancy. This program is proposed to be implemented in 19 counties state-wide that have the highest rates of births among teens ages 15-19. Two goals of TOP are to reduce pregnancy rates and increase high school graduation rates.

Innovative Social Media -- The purpose of this grant is to improve birth outcomes through socially interactive educational media. The media will improve understanding of the consequences of behavioral and environmental life choices on pregnancy outcomes. Socially interactive media will provide engaging, challenging and educational experiences that will be able to be spread beyond the original participants through shared media access.
MCH is proposing to develop and implement The Social Immersive Media Project for Life-course Education (SIMPLE). SIMPLE is an innovative social marketing approach to increase public awareness of the importance of integrating the life-course perspective into preconception/interconception planning and care; to reduce adverse outcomes and improve reproductive health; and to increase public awareness of the importance of preparing couples for transitioning into their roles as new parents.

ACA Maternal, Infant and Early Childhood Home Visiting Program Application -- Research indicates that healthy human development is connected to preventing poor outcomes that occur during the youngest years of a child's life. Early health indicators, including birth weight, immunization rates, and parental knowledge of proper child development, all are significant predictors of school performance and social engagement in later years. Problems apparent at this young age have been accurate predictors of IQ, educational attainment, criminal behavior, and even the probability of becoming a teenage mother. Programs that focus on comprehensive family-based programs have yielded strong outcomes for children, especially when they begin as early as possible. Home visitation programs that train new parents to be the "first teachers" of their young children have been very successful, especially if these programs work with parents over a period of several years.
In keeping with the partnership between HRSA and ACF, Indiana's Governor, the Honorable "Mitch" Daniels, has also recognized that the goal of an effective, comprehensive early childhood system is broader than the scope of any one agency. He has designated The Indiana State Department of Health (ISDH), through the Maternal and Child Health (MCH) Title V Division, and the Indiana Department of Child Services (DCS) as co-lead agencies for the State of Indiana's application for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Indiana will use this funding for two programs. Specifically, Indiana proposes to expand Healthy Families services within the already existing statewide network of Healthy Families providers, and to pilot the Nurse-Family Partnership home visiting services through a public-private partnership between ISDH/MCH and Goodwill Industries of Central Indiana.

We are also defining and implementing an evidence-based, life course health perspective that supports the knowledge that health is more than the absence of disease. As MCH moves in this direction, we are addressing a life course approach at the organizational level; developing and testing programs that incorporate a life course perspective; promoting pilot projects to test models that can be adopted and adapted in other locales; and sharing strategies and outcomes with non-traditional partners such as Goodwill Industries to further enhance knowledge, theory and practice.

G. Technical Assistance

National Fatherhood Initiative

Indiana State Department of Health (ISDH) is requesting technical assistance for Best Practices training for new fathers on the basics of child health and safety. This will teach fathers how to take care of their children during the pregnancy and after they are born. Early involvement of males in the pregnancy has positive benefits well beyond the birth of the child. For example, trainings engaging new dads and fathers in addressing the babies needs while in the womb and after delivery have shown to assist mothers in receiving early, continuous, and adequate prenatal care. This can be due to the fact that the mothers have a support system from the start.

Unmarried mothers, or mothers where the fathers are absent from the home, are less likely to obtain prenatal care and more likely to have a low birth-weight baby. Researchers find that these negative effects persist even when they take into account factors such as education, which often distinguish a single parent from two-parent families. Expectant fathers can play a powerful role as advocates for prenatal care. Research has shown that 2/3rds of women whose partners attended a breastfeeding promotion class initiated breastfeeding. When the father or other family male(s) were involved, the mother received more prenatal care once enrolled.

ISDH is requesting technical assistance regarding the National Fatherhood Initiative (NFI). NFI offers Best Practices curriculums that actively involve fathers in the child's health care from conception and throughout childhood. Their curriculums include a variety of tools and resources for supporting fathers in many diverse settings. For example, they offer military programming, school-based programming, correctional programming, and Christian-based programming. For our purposes, we are interested in their health care programming which includes but is not limited to "Doctor Dad", "When Duct Tape Won't Work", and "Daddy Pack" (Exclusively for New Dads).

Bright Futures

ISDH is requesting training on the usage of the Bright Futures developmental tools for families and providers to address social and emotional health in children 0 through 5. This training should address each child's uniqueness due to the fact that all children face social and emotional challenges in early childhood, including learning how to control their emotions and tantrums and learning how to share, take turns, and play with others. With the use of Bright Futures tools, providers and families can begin a conversation together about how best to support healthy social and emotional development in infants, children, and teens. The tools encourage families who have any questions or concerns about their child's development to "check it out" and offer a number of tips for when, where, and how to seek assistance from local, state, or national resources.

Customized training, consultation, and technical assistance are available from Bright Futures at Georgetown University and the National Technical Assistance Center for Children's Mental Health. Through these organizations, ISDH would be able to utilize these tools in a variety of settings and for multiple purposes.

Capacity building for coalitions

ISDH is requesting technical assistance for infrastructure building and capacity building for coalitions. The Indiana Coalition to Improve Adolescent Health (ICIAH) was formed in late 2006. In May 2009, ICIAH released the state's first adolescent health plan. The focus of ICIAH is on the implementation of this plan with and through its partner organizations. However, ICIAH is struggling to get buy-in and commitment from its partners to take greater ownership in the implementation of the plan and promotion of ICIAH's work.

Cultural Competency Training
General issue-cultural competency training for MCH and its partners would be beneficial because Maternal and Child Health (MCH) faces diversity and health disparities among the population it serves. ISDH did provide annual training opportunities and refresher courses on cultural competency; however, such opportunities are no longer available. It is important for MCH staff and those we partner with and fund to have skills in this area in order to provide the best services for its clients. This type of training is available through MCHB and the National Center for Cultural Competency.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	14210461	10989375	11779106		11770865	
2. Unobligated Balance *(Line2, Form 2)*	0	781490	0		781000	
3. State Funds *(Line3, Form 2)*	19065236	15851443	17877130		17877130	
4. Local MCH Funds *(Line4, Form 2)*	1146380	1527825	1527825		250317	
5. Other Funds *(Line5, Form 2)*	3076071	2501598	2154034		2696549	
6. Program Income *(Line6, Form 2)*	2586655	3011077	2831064		2923311	
7. Subtotal	40084803	34662808	36169159		36299172	
8. Other Federal Funds *(Line10, Form 2)*	2963390	2431774	2780834		2462219	
9. Total *(Line11, Form 2)*	43048193	37094582	38949993		38761391	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	7503631	7494380	6287515		5389351	
b. Infants < 1 year old	1876093	613177	1636633		2442372	
c. Children 1 to 22 years old	7376058	8005360	7512902		8016995	
d. Children with	22667176	17952447	20058653		19802771	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	661845	597444	673456		647683	
g. SUBTOTAL	40084803	34662808	36169159		36299172	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		91090		92090	
c. CISS	140000		104953		0	
d. Abstinence Education	566556		565826		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	1611410		1468365		1554529	
j. Education	0		0		0	
k. Other						
ECCS	0		0		140000	
PSUPP	400780		400600		400600	
UNHS	150000		150000		275000	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	17805732	16534160	5688485		16285863	
II. Enabling Services	10676564	12062658	17477119		7478809	
III. Population-Based Services	3793473	970558	5622458		6198615	
IV. Infrastructure Building Services	7809034	5095432	7381097		6335885	
V. Federal-State Title V Block Grant Partnership Total	40084803	34662808	36169159		36299172	

A. Expenditures

A. EXPENDITURES

Indiana's recent cost cutting measures include , a personnel voluntary furlough program, statewide salary freeze for the past two years, elimination of non-crucial State positions, and a requirement that all new or replacement State positions be approved by the State Strategic Hiring Committee. These initiatives were implemented regardless of funding source. It is expected that these measures will continue over the next fiscal year. The long-term impact will result in significant expenditure reductions for both state and federal funds in FY 2011 as reflected on Form 3, Form 4, and Form 5.

Maintenance of State Effort
Indiana's Maintenance of State Effort is $11,539,520. In FY 2011 the MCH expected award is

$11,770,865 and the state has available $36,299,172. The State support is comprised of state and local funds that MCH and Children with Special Health Care Services are authorized to spend on behalf of children with special health care needs. It also includes money for the 30% match required of local projects.

B. Budget

Annual Budget and Budget Justification

Indiana has budgeted $3,624,106.00 or 30.8% of its annual budget for services to pregnant women, mothers and infants up to age one. Indiana has budgeted $3,569,158.00 or 30.3% of its annual budget for family-centered, community-based, coordinated care and the development of community-based systems of care for children with special health care needs and their families. Indiana has budgeted $3,929,918.00 or 33.4% of its annual Title V budget to provide services to preventive and primary care services for child and adolescents. Also included in this amount is $647,683.00 or 5.5% for administrative costs. This is 100% of the total MCH grant award.

$16,285,863.00 has been budgeted for direct medical care services, which includes all community grants that provide direct services and payment of projected medical claims for CSHCS.

$7,478,809.00 has been budgeted for enabling services which include all community grants that provide enabling services, and all other CSHCS state funds not projected for direct medical care services.

$6,198,615.00 has been budgeted for population based services. These services include all community grants that will provide population based services, Newborn Screening funds, and Indiana RESPECT funds.

$6,335,885.00 has been budgeted toward Infrastructure Building Services and these funds include salaries for all staff and other operating expenses (less insurance premiums), community grant funds, the statewide needs assessment, data systems, and the Indiana Perinatal Network.

FY 11 Unobligated Funds
The projected unobligated balance for FY 11 is $781,000.00. These funds are a combination of funds that were not expended due to the overall statewide cost cutting measures. Due to the State salary freeze, MCH has been unable to fill positions in a timely manner or use funds for salary increases.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.